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In the

Supreme Court of the United States

October Term, 1966

No. 277

DR. FRANK M. FERRANTE,

Appellant,

v.

THE CITY OF NEW YORK, ROBERT F. WAGNER as Mayor of the City of New York, and DR. RAY E. TRUSSELL as Chairman and Commissioner of the Board of Hospitals of the City of New York,

Appellees.

On Appeal from the Court of Appeals of the State of New York

JURISDICTIONAL STATEMENT

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JURISDICTIONAL STATEMENT

Appellant Dr. Frank M. Ferrante appeals from the final order/judgment (A-9, R-45)* of the New York Court of Appeals, made and entered on March 24, 1966, which affirmed the order of the Appellate Division, First Department (R41), which in turn had affirmed the order/judgment (one paper)(R-39), of the New York County Supreme Court Special Term (Part I) granting summary judgment for Appellees and holding that the New

* "A" references are to pages of the Appendix herein and "R" references are to pages of the certified Record.

York City Proprietary Hospital Code[1] was constitutional.

Appellant Dr. Ferrante submits this Statement to show that the Supreme Court of the United States has jurisdiction of the appeal and that substantial federal questions are presented.

OPINIONS BELOW

The New York County Supreme Court, Special Term (Part I), rendered an opinion which was not officially or unofficially reported (A-1, R-31).

The Appellate Division, First Department, rendered no opinion.

The New York Court of Appeals rendered no opinion.

JURISDICTION

Appellant, Dr. Ferrante, together with Drs. Cherico and Daly (whose participations in this case have been abandoned), commenced a declaratory judgment action in the New York County Supreme Court, pursuant to C.P.L.R. §3001 (McKinney's Consolidated Laws of New York, Annotated, Book 7 B), for the sole purpose of declaring unconstitutional the New York City Proprietary Hospital Code (R-1).

Appellant Dr. Ferrante has at every stage of the proceedings below asserted that the code as drawn and as applied to him was repugnant to the Constitution of the United States (A-9, R-6).

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[1] The New York City Hospital Code, Part II, Proprietary Hospitals, Articles XII and XIII through XVI, hereinafter sometimes referred to as the "Code".

The Order/Judgment (one paper) of the New York Court of Appeals was made and entered on March 24, 1966 (A-9, R-45).

The Notice of Appeal to the Supreme Court of the United States was filed in the New York County Supreme Court on May 19, 1966 (R-49).

The jurisdiction of the Supreme Court to review the decision of the New York Court of Appeals is conferred by Title 28, United States Code, Section 1257(2), since the validity of a state statute[2] is drawn in question on grounds of repugnancy to the Constitution of the United States, and the decision of the Court below is in favor of its validity.

The following decisions sustain the jurisdiction of the Supreme Court to review the order/judgment (one paper) on appeal in this case: Cummings v. Missouri, 4 Wall. 277; Ex parte Garland, 4 Wall. 333; Griswold v. Connecticut, 381 U.S. 479; Palko v. Connecticut, 302 U.S. 319; Poulos v. New Hampshire, 345 U.S. 395; Robinson v. California, 370 U.S. 660.

If the appeal should be considered as having been improvidently granted the Court is requested to consider such appeal as a petition for Certiorari, under Title 28, U.S.C. §2103.

STATUTES INVOLVED

Because of its length, the New York City Proprietary Hospital Code (the New York City Hospital Code, Part II, Proprietary Hospitals,

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[2] Here, a city ordinance; see *Poulos v. New Hampshire*, 345 U.S. 395, 402.

Articles XI and XIII through XVI) is set forth in its entirety at pages 13-53 of the appendix herein.

Amendments to the Constitution of the United States, Article VIII, provides (1 United States Code, 1952 Edition, XLIV):

> "Excessive bail shall not be required nor excessive fines imposed, nor cruel and unusual punishments inflicted."

Amendments to the Constitution of the United States, Article IX, provides (1 United States Code, 1952 Edition, XLIV):

> "The enumeration in the Constitution of certain rights, shall not be construed to deny or disparage others retained by the people."

Amendments to the Constitution of the United States, Article XIV, provides in part (1 United States Code, 1952 Edition, XLV):

> "Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

QUESTIONS PRESENTED

1. Does the New York City Code's imposition of retroactive qualifications on, and its resultant prohibition of, Appellant Dr. Ferrante being allowed to continue to practice his speciality of surgery in proprietary hospitals[3] in New York City, despite the facts that he is licensed by New York State to practice medicine and surgery and that he has done so for over fifteen years, constitute cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments, violate the due process and equal protection clauses of the Fourteenth Amendment, constitute punishment without trial in violation of the Fourteenth Amendment, and violate the Ninth Amendment's reservation of rights to the people, and therefore did the New York Court of Appeals err in failing to declare the entire Code unconstitutional (there being no separability clause), or at least those sections which now prohibit Appellant Dr. Ferrante from continuing to practice his profession?

STATEMENT

In June of 1964 a resolution was adopted by the New York City Board of Hospitals, a non-elective body of nine persons, which amended the New York City Hospital Code by adding thereto Articles XI and XIII through XVI. Corrected amendments were filed with the City Clerk on August 7, 1964 and published in The City Record on August 11, 12 and 13, 1964. Article XIV thereof was further amended by resolution of the Board of Hospitals on September 23, 1964, and the amend-

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3 Proprietary hospitals are private hospitals, as differentiated from charity hospitals and governmental hospitals.

ments were filed with the City Clerk on September 25, 1964 and published in The City Record on September 29 and 30 and October 1, 1964.

Thus, new Articles XI and XIII through XVI of the New York City Hospital Code became law, and now constitute the Hospital Code of the City of New York and Regulations, Part II, Proprietary Hospitals (A13).

Prior to the adoption of the Code, as aforesaid, it was never legally required by any governmental, professional, or other kind of body, for the practice of surgery in a proprietary hospital in New York City that one (1) be a Diplomate of the American Board of Surgery, or (2) be a Fellow of the American College of Surgeons, or (3) be notified of admissibility to examination by the American Board of Surgery or present evidence of completion of a residency in surgery approved by the American Medical Association, or (4) hold the rank of Attending or Associate Attending Surgeon in an accredited charity or governmental hospital or have held either of these ranks during the five years prior to the adoption of the Code.

Prior to the adoption of the Code, as aforesaid, it was never legally required, for the practice of surgery related to the fields of obstetrics and gynecology in a proprietary hospital in New York City that one (1) be a Diplomate of the American Board of Obstetrics and Gynecology, or (2) be a Fellow of the American College of Surgeons in the speciality of obstetrics and gynecology, or (3) be notified of admissibility to examination by the American Board of Obstetrics and Gynecology or present evidence of completion of a residency in obstetrics and gynecology approved by the

American Medical Association, or (4) hold the rank of Attending or Associate Attending Obstetrician in an accredited charity or governmental hospital, or have held either of these ranks during the five years prior to the adoption of the Code.

However, as a prerequisite to continuing to practice these surgical and surgical-related-to-obstetrics-and-gynecology specialities in a proprietary hospital in New York City the New City Code imposed the above qualifications, and it imposed therein retroactively (A-18, 39 at sections 11.01(l), 11.01(m), 15.07(b)(1) and others of the Code). That is, if one did not in the past possess them, he could not continue to practice in the future.

Because for the fifteen years prior to the Code's adoption, and prior to its imposition of the above retroactive qualifications, Appellant Dr. Ferrante had practiced all types of major surgery in those proprietary hospitals with which he was associated as a staff member solely by virtue of his New York State license to practice medicine and surgery, by virtue of his patients' confidence in his ability, and by virtue of the willingness of the private hospitals where he worked to allow him to exercise his skills there (R-5,6), and because he had never obtained any of the theretofore purely voluntary, optional, and never legally required "qualifications" without which he could not now continue to practice his profession in New York City (R-1,2), Appellant Dr. Ferrante commenced an action to declare the Code unconstitutional both as drawn and as applied to him.

His complaint alleged all of the aforesaid facts (R-1), and also that therefore as to him the Code was unconstitutional as a deprivation of

property without due process and a denial of equal protection in violation of the Fourteenth Amendment (R-6), that it subjected him to cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments (R-6), that it subjected him to punishment without trial in violation of the Fourteenth Amendment (R-6), and that it violated the Ninth and Fourteenth Amendments' reservation of rights to the people (R-6).[3]

Before answering, Appellees moved to dismiss the complaint under New York's Civil Practice Law and Rules §3211(a)(7) (R-11), for its alleged failure to state a cause of action. Special Term (Part I) treated the motion as one for summary judgment,[4] and held the Code constitutional as against Appellant Dr. Ferrante's challenges (A-1,8, R-31, 37).

As to the imposition of retroactive qualifications, which he neither possessed nor ever before legally or otherwise ever had to possess, on Appellant Dr. Ferrante's continued practice of his profession in New York City, the Court held that "[t]he provisions of the 1964 revisions to the Code do not violate the due process requirement of the United States Constitution or any of the other constitutional provisions invoked in the complaint" (A-8, R-37).

From Special Term's order and judgment (one paper) (R-39), in favor of the Code's constitutionality Appellant Dr. Ferrante appealed as of right to the Appellate Division, First Department, raising the identical constitutional issues as before. That

[3] Other constitutional infirmities of the Code which were raised in the complaint and the notice of appeal by Appellant Dr. Ferrante, and the other original Plaintiffs, have been abandoned here.

[4] C.P.L.R. sec. 3211 (c).

Court unanimously affirmed, without opinion (R-41).

From the Appellate Division's affirmance, Appellant Dr. Ferrante appealed as of right to the New York Court of Appeals (R-44). Once again, he raised the identical constitutional issues that he had previously urged on both Special Term and the Appellate Division. The Court of Appeals then also unanimously affirmed, also without opinion, thereby holding the Code in all respects constitutional against Appellant Dr. Ferrante's challenges (A-9, R-45).

Because there was no opinion written there, Appellant Dr. Ferrante moved in the Court of Appeals to amend that Court's Remittitur to reflect the fact that the aforesaid federal constitutional questions were both presented and passed upon.

The motion was granted and the amended Remittitur (A-9, R-45) now reflects the fact that on appeal to the Court of Appeals the aforesaid federal constitutional questions were presented and necessarily passed upon.

As may be seen from the above, the federal constitutional questions here were not only raised throughout and at every stage of the New York proceedings, but they were in fact the very reason and basis for the original declaratory judgment action itself, and the action was predicated solely upon such questions. Since only federal constitutional objections were ever asserted, as the Court of Appeals' amended Remittitur shows, every one of the three New York decisions rested exclusively on the federal constitutional grounds presented here (A-9, R-45).

Upon the decision of the New York Court of Appeals, the State's court of last resort, upholding the Code's constitutionality, that Court's order/judgment (one paper) was the final one in the action and it was rendered in the highest court of New York in which a decision could be had. From that order/judgment (one paper) this appeal is brought here.

THE QUESTION IS SUBSTANTIAL

First, a disclaimer is necessary: the instant case does not challenge the long-standing proposition in this Court that a State may regulate the practice of professions such as medicine, dentistry and law, establishing reasonably necessary qualifications, and requiring licensing and supervision of the practitioners by administrative boards; nor that the result sought by such regulation is that of affording protection against ignorance, incapacity, and imposition (Dent v. West Virginia, 129 U.S. 114, 9 S. Ct. 231; Watson v. Maryland, 218 U.S. 173, 30 S. Ct. 644; Crane v. Johnson, 242 U.S. 339, 37 S. Ct. 176; Douglas v. Noble, 261 U.S. 165, 43 S. Ct. 303; Graves v. Minnesota, 272 U.S. 425, 47 S. Ct. 122; Hayman v. Galveston, 273 U.S. 414, 47 S. Ct. 363; Semler v. Oregon State Board of Dental Examiners, 294 U.S. 608, 55 S. Ct. 570).

Appellant Dr. Ferrante was duly licensed on March 25, 1947 by New York State to practice "medicine and surgery" (R-1), and from that day to this one New York State has made no change or alteration whatsoever in his license.

However, notwithstanding Appellant Dr. Ferrante's New York State license to practice medicine

and surgery; notwithstanding that he has possessed that license for more than nineteen years; notwithstanding that his license and reputation has been and is now wholly without even the faintest blemish; notwithstanding that in his nineteen years of practicing his medical speciality of surgery he has regularly performed breast cancer surgery, biliary tract surgery, gastronomical surgery, gall bladder surgery, appendectomies, thyroid and tonsil surgery, as well as surgery connected with obstetrics and gynecology, such as ceasareans, hysterectomies, breach deliveries, and all other types of complicated deliveries requiring heavy or major surgery (R-1); notwithstanding that he has patients who desire that he continue to perform surgery on them; notwithstanding that there are proprietary hospitals in New York City which desire him to continue to perform surgery there; and notwithstanding that Appellant Dr. Ferrante himself desires to continue to practice his medical speciality of surgery in proprietary hospitals in New York City, since late 1964 he has been legally prohibited from practicing his profession in any proprietary hospital in New York City solely because of the Code.

The City Code has literally put Dr. Ferrante out of business, it has literally destroyed his profession, not for being unqualified under the laws, rules and regulations of the only sovereign which has power to control the exercise of his profession — New York State, not because he is trying to foist himself upon unwilling patients and/or proprietary hospitals — because they both do want him, not because he has suddenly become unqualified — for after nineteen years he is even more qualified than ever, not because he refuses to do something new that is required of him, not

because he did something wrong in the past which has just come to light, and not because it has been discovered that his original professional training was insubstantial or incomplete.

Rather, the City Code has literally put Dr. Ferrante out of business, it has literally destroyed his profession; because in the past he had never opted to take certain steps — become a Diplomate or Fellow, have an A.M.A. approved residency, or obtain rank in a charity or governmental hospital — which were always heretofore completely voluntary goals which one could seek if he chose to, but which were never necessary legally, ethically or in any other manner to the practice of medicine and surgery under federal, state, local or any other law, rule or regulation.

The City Code has literally put Dr. Ferrante out of business, it has literally destroyed his profession, because in the past he failed to do things which he never had a legal, moral or ethical obligation to do.

It is not amiss to observe here that what has happened to Dr. Ferrante would be equivalent to the passage of a law providing that a New York City lawyer could no longer practice before the American Arbitration Association (even though the A.A.A. would allow it, and even though he had a client who desired his representation there) unless sometime in the past the lawyer had been a member of the American, State, City or County Bar Association, or had had an A.B.A. approved clerkship, or for a certain period of time had worked for and obtained a certain rank at the legal Aid Society or the District or State or United States Attorney's office.

Yet, both New York Appellate Courts agreed with Special Term that "The provisions of the 1964 revisions to the code do not violate the due process requirements of the United States Constitution or any of the other constitutioal provisions invoked in the complaint" (A-8, 9, R-37, 41, 45).

Does the New York City Code's imposition of these retroactive requirements on Dr. Ferrante's continued practice of his profession in New York City present substantial constitutional questions? Respectfully, we suggest that it does.

The first relevant observation here is that there is not one decision of this Court which forecloses the question against Dr. Ferrante. As we said above, we do not here challenge New York State's power to license and otherwise control the practice and practitioners of medicine in that State. Nor is it even necessary to here challenge (although it is not conceded) New York City's power to also somehow generally regulate doctors. One thing only is challenged here: New York City's imposition of retroactive requirements for the continued practice of surgery in proprietary hospitals in New York City by a physician who is duly licensed by New York State to practice medicine and surgery.

At every stage in the state courts, repeated and consistent attack was made against what the Code does to Dr. Ferrante. It was alleged there, and it is alleged here, that:

(1) He is visited with cruel and unusual punishment (Amendments Eight and Fourteen),

(2) He is deprived of his property without due process of law (Amendment Fourteen),

(3) He is deprived of equal protection of the law (Amendment Fourteen),

(4) He is punished without benefit of trial (Amendment Fourteen),

(5) His vested right to his profession reserved to him by the Constitution, has been abolished (Amendment Nine).

Cruel and Unusual Punishment

A substantial constitutional question is raised under the Eighth and Fourteenth Amendments. In Trop v. Dulles, 356 U.S. 86, 78 S. Ct. 590, speaking for four members of the Court the Chief Justice said that:

> "The exact scope of the constitutional phrase 'cruel and unusual' has not been detailed by this Court. But the basic policy reflected in these words is firmly established in the Anglo-American tradition of criminal justice. The phrase in our Constitution was taken directly from the English Declaration of Rights of 1688, and the principle it represents can be traced back to the Magna Charta. The basic concept underlying the Eighth Amendment is nothing less than the dignity of man. While the state has the power to punish, the Amendment stands to assure that this power be exercised within the limits of civilized standards." (356 U.S. at 99, 78 S. Ct. at 597).

With these and other antecedent considera-

tions as a foundation, the Court concluded that:

> "...use of denaturalization as a punishment is barred by the Eighth Amendment. There may be involved no physical mistreatment, no primitive torture. There is instead the total destruction of the individual's status in organized society" (356 U.S. at 101, 78 S. Ct. at 598).

In the context thus established by Trop v. Dulles, supra, on the Eighth Amendment point, two incontrovertible facts stand out concerning Dr. Ferrante: although he has done nothing wrong, he can no longer practice his profession in a proprietary hospital in New York City. Whether or not what has happened to him is literally deemed "punishment," [5] one thing is clear: through no fault or even act of his own, he has been professionally destroyed. The question thus arises as to whether a substantial question exists under the Eighth and Fourteenth Amendments when New York City simply wipes out a doctor's professional life because in the past he once failed to do something which he was never obliged to do?

The question of substantiality is answered affirmatively by the observations of Mr. Justice Douglas in his dissent in Barsky v. Board of Regents of University of State of New York, 347 U.S. 442, 74 S. Ct. 650, cited here not for precedential value, but rather because part of the formulation of the issue by him there corresponds perfectly with our position here, the herequoted parts of which formulation we underwrite completely:

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5 See *Cummings v. Missouri*, 4 Wall. 277 and *Ex parte Garland*, 4 Wall. 333 to the effect that deprivation of the right to follow one's profession is punishment.

> "The right to work, I had assumed, was the most precious liberty that man possesses. Man has indeed as much right to work as he has to live, to be free, to own property .... It does many men little good to stay alive and free and propertied, if they cannot work. To work means to eat. It also means to live. For many it would be better to work in jail, than to sit idle on the curb. The great values of freedom are in the opportunities afforded man to press to new horizons, to pit his strength against the forces of nature, to match skills with his fellow man .... [The Bill of Rights] is not an instrument of dispensation but one of deterrants. Certainly a man has no affirmative right to any particular job or skill or occupation. The Bill of Rights does not say who shall be doctors or lawyers or policemen. But it does say that certain things are protected, that certain things shall not be done. And so the question here is not what government must give, but rather what it may not take away" (347 U.S. at 472, 74 S. Ct. at 666).

Regardless of what we may think of the Barsky majority holding, the fact is that there the doctor had done something which the regents and/or the courts considered wrong. Here, Dr. Ferrante has done absolutely nothing; his only mistake was that he failed to do something he was never required to do.

When in Robinson v. California, 370 U.S. 660, 82 S. Ct. 1417, this Court held the Eighth Amendment applicable to the states through the Fourteenth, it held that to punish a narcotics addict simply

for occupying the status of an addict would be cruel and unusual. Is it any less cruel to allow New York City to destroy Dr. Ferrante's profession simply because he never did what he was never under any obligation to do? Again, just as Barsky had done something, at least Robinson was an addict — but Dr. Ferrante has done nothing, just as Robinson could not be punished for occupying the mere status of an addict, Dr. Ferrante's surgical practice can not be wiped out because of his status of not being a Diplomate, a Fellow, not having an A.M.A. approved residency, and not having obtained rank in a government or charity hospital.

While the early Eighth Amendment cases dealt with the punishment's severity or how much cruelty was present, envolving recognition that there are more subtle ways of government being cruel and inhuman to its citizens has caused this Court to quite properly scrutinize how people are treated, particularly the innocent, like Robinson. Dr. Ferrante is innocent, too. If this Court refused in Robinson to make addiction a crime and refused to allow addicted people to be punished for merely being addicted, if as Justice Douglas said there "This age of enlightenment cannot tolerate such barbarous action (370 U.S. at 678, 82 S. Ct. at 1426), how can it allow Dr. Ferrante to be destroyed professionally when he is wholly innocent of everything and when he is licensed by New York State to practice medicine and surgery?

A substantial constitutional question is presented under the Eighth and Fourteenth Amendments.

Due Process, Punishment Without Trial, and Equal Protection

It has been held to be a deprivation of property without due process of law for a State to deny employment to a teacher who, though a member of a so-called subversive organization, is wholly innocent of any unlawful purpose, activity or acts (Wieman v. Updegraff, 344 U.S. 183, 73 S. Ct. 215). The City Code's prohibition of Dr. Ferrante's practicing surgery in a proprietary hospital in New York City is no less a deprivation of his property without due process.

It has been held in Schware v. Board of Bar Examiners of the State of New Mexico, 353 U.S. 232, 77 S. Ct. 752, that:

> "A state[6] cannot exclude a person from the practice of law or from any other occupation in a manner or for reasons that contravene the due process or equal protection clause of the Fourteenth Amendment" (353 U.S. at 238, 77 S. Ct. at 756).

Footnoting the above quotation, the Court passed over the question of whether the practice of law was a "right" or a "privilege", and cited with approval Ex parte Garland, supra, the companion case to Cummings v. Missouri, supra, for the proposition that:

> "...it is sufficient to say that a person cannot be prevented from practicing except for valid reasons. Certainly the practice of law is not a matter of the State's grace." (4 Wall. at 379).

[6] Here, of course, the irony is that the State has licensed Dr. Ferrante, but the City has effectively nullified that license.

Continuing, the Court acknowledged that:

> "A State can require high standards of qualification, such as good moral character or proficiency in its law, before it admits an applicant to the bar, but any qualifications must have a rational connection with the applicant's fitness or capacity to practice law. ....Obviously an applicant could not be excluded merely because he was a Republican or a Negro or a member of a particular church. Even in applying permissible standards, officers of a State cannot exclude an applicant when there is no basis for their finding that he fails to meet these standards, or when their action is invidiously discriminatory." (353 U.S. at 238, 77 S. Ct, 756).

New York State does require high standards for the practice of medicine there, and nearly twenty years ago Dr. Ferrante met the State's standards and was licensed. Consistent with the mandate of due process there is no way whatsoever to hold that now, twenty years later, New York City can exclude Dr. Ferrante from the practice of surgery and effectively destroy his State license, solely because he never took action which no one — not even the state — ever required him to take.

Both Cummings v. Missouri and Ex parte Garland, supra, have never been overruled by this Court, and the latter held that deprivation of the right to follow one's profession is punishment (see also United States v. Lovett, 328 U.S. 303, 66 S. Ct. 1073). That the code has deprived Dr. Ferrante of his right to practice surgery in a

proprietary hospital in New York City is clear. Thus, that he has been punished is clear. Yet no one — not the State which continues to license him, nor the City which has effectively destroyed that license — even attempts to point to anything he has done wrong.

It is bad enough for a government to do what Mr. Justice Douglas discussed in dissent in Gardner v. Board of Public Works, 341 U.S. 716, 71 S. Ct. 909:

> "Deprivation of a man's means of livelihood by reason of past conduct, not subject to this penalty when committed, is punishment whether he is a professional man, a day laborer who works for private industry, or a government employee. The deprivation is nontheless unconstitutional whether it be for one single past act or a series of past acts." (341 U.S. at 735, 71 S. Ct. at 919).

Needless to say, it is infinitely worse when one is punished, as Dr. Ferrante is, though in the past he did nothing wrong whatsoever.

Dr. Ferrante is punished by New York City today not for what he is today, not even for what he once was — but, rather, for what he once was not, even though at the time he had no legal, moral or ethical reason to be what New York City now says he ought to have been.

Only a few years ago this Court had occasion again to deal with the subject of punishment imposed in violation of the due process clause. In Kennedy v. Mendoza-Martinez, 372 U.S. 144

83 S. Ct. 554, this Court held that deprivation of citizenship was punishment in violatin of the Fifth and Sixth Amendments, visited upon one who left or remained outside of the country to evade military service. Here, Dr. Ferrante not only did not evade military service, he did nothing at all wrong. Yet, just as Mendoza-Martinez and Cort were stripped of their citizenship (until this Court restored it), Dr. Ferrante has been stripped by New York City of his right to practice his profession, his right to practice surgery in a proprietary hospital if the hospital and a patient want him to do so. However, Dr. Ferrante had no lawyer, no trial, no hearing, and no opportunity to be confronted with witnesses against him—there is not even a statute which anyone can point to and say that under it Dr. Ferrante did something wrong. Instead, we have a man who has been punished for having committed no act, no statute exists making anything wrong which he could be accused of doing, and New York City has unilaterally prevented him from being a surgeon there despite his license from the State. All this has happened to him, his livelihood has been wiped out, and yet the trial court found no constitutional objections, and neither of the New York appellate courts saw fit even to write an opinion.

If substantial constitutional questions under the due process clause are not raised by the Code's unilateral and retroactive destruction of Dr. Ferrante's right to be a surgeon in New York City, and its effective destruction of his State license, it is indeed difficult to imagine what would be sufficient to raise such questions.

As to a substantial constitutional question

being raised under the equal protection clause, mention should be made of the fact that under the Code only the surgical practice of doctors in proprietary hospitals is affected.

Although the reach of the policy power is wide, of course it must be exercised evenly under the Constitution so as to bear upon all who are affected by it without discrimination (Yick Wo v. Hopkins, 118 U.S. 356).

Surely it cannot be said that in the Code involved here New York City's police power does not discriminate between those surgeons without the so-called "qualifications" who choose to practice in proprietary hospitals, and their colleagues without the so-called "qualifications" who choose and who are allowed to practice in charity and governmental hospitals. The latter group can work, the former can not. It hardly needs to be observed that if the discrimination is based on where a surgeon works, rather than on any other considerations, the distinction is constitutionally unsupportable against an equal protection challenge.

A substantial constitutional question is thus presented under the equal protection clause.

The Ninth Amendment

As we have said right from the start of this case, and many times since, the Code's prohibition of Dr. Ferrante's continuing to practice surgery in proprietary hospitals in New York City violates one of the rights reserved to him under the Ninth Amendment.

While this Amendment has never itself ever

determined any case in this Court, or in any other American court for that matter (Griswold v. Connecticut, 381 U.S. 479, 490, 85 S. Ct. 1678, 1685), "[i]t can not be presumed that any clause in the constitution is intended to be without effect." (Marbury v. Madison, 1 Cranch. 137, 167).

As recently as a year ago this Court's majority opinion in Griswold stated that the Ninth Amendment along with other "[v]arious guarantees create zones of privacy" (381 U.S. at 484, 85 S. Ct. at 1681). Despite the obvious fact that neither the Constitution nor the Bill of Rights expressly protected the rights of marital privacy contended for there, the majority recognized it anyway.

The concurring opinion, premised solely on the Ninth Amendment, makes it clear that there are many rights protected beyond those specifically enumerated, among them the right to use and receive information about contraceptives.

Dr. Ferrante's right to continue to practice his profession in proprietary hospitals in New York City, after obtaining an education and a license from New York State and after devoting nearly twenty years to perfecting his skills as a surgeon, is no more enumerated in the Constitution or Bill of Rights than was Mrs. Griswold's patient's right to marital privacy. But can we say out-of-hand that Dr. Ferrante's right is any less protected? We think not. We think that Griswold alone amply demonstrates the substantiality of the constitutional question raised here under the Ninth Amendment.

In sum, as to all the points raised above — cruel and unusual punishment, due process, punish-

ment without trial, equal protection, and the Ninth Amendment — Appellant Dr. Ferrante holds the conviction that the questions presented by this appeal are indeed substantial, of great public importance, and merit plenary consideration by this Court.

Respectfully submitted,
HENRY MARK HOLZER
35 East 35th Street
New York City 10016
(212) MU 5-4265
Lawyer for Appellant

APPENDIX

OPINION OF SPECIAL TERM

FERRANTE v. CITY OF N.Y.—This is a motion, pursuant to Rule 3211(a) subsection 7, CPLR, to dismiss the complaint for alleged failure to state a cause of action. As permitted by subdivision (c) of the Rule, defendants have submitted an affidavit, and the court may, therefore, as provided in said subdivision, treat the motion as one for summary judgment.

The action is brought by three physicians for (1) an adjudication that the 1964 revisions of the Hospital Code are illegal and unconstitutional; and (2) an injunction against enforcement of the Code by defendants, the City of New York, Mayor Wagner, and Dr. Trussell as Chairman and Commissioner of the Board of Hospitals of the City of New York.

One of the plaintiffs, Dr. Ferrante, alleges that for over fifteen years he has specialized in every type of major surgery, including surgery related to obstetrics and gynecology; that the new provisions of the Code dealing with proprietary hospitals, forbid the practice of major or complicated surgery in such hospitals except by a "qualified surgeon" (section 15.02[c]; that a "qualified surgeon" is a physician holding a current license to practice medicine in New York State, who is either (1) "a Diplomate of the American Board of Surgery"; or (2) "a Fellow of the American College of Surgeons"; or (3) who "has been notified of admissibility to examination by the American Board of Surgery or presents evidence of completion of a residency in Surgery approved by the

American Medical Association"; or (4) who "holds the rank of Attending or Associate Attending Surgeon in an accredited voluntary or governmental hospital or has held either of these ranks during the five [5] years prior to the adoption of this Code" (section 11[1] 1, 2, 3, 4); that the new Code imposes similar requirements for a "qualified obstetrician"; that Dr. Ferrante does not meet these requirements; and that he is, therefore, barred from continuing to do major surgery in proprietary hospitals. Dr. Ferrante alleges that the enactment of the new provisions by the Board of Hospitals was without legislative authority; that they violate the due process clause of the 14th Amendment to the United States Constitution as well as the equal protection clause of that Amendment; and that the retroactive application of said qualifications as conditions precedent to his continuing to perform surgery in proprietary hospitals, in addition to violating due process, subjects him to cruel and unusual punishment.

Plaintiff, Dr. Cherico, alleges he has engaged in the general practice of medicine for over seventeen years, utilizing the facilities of proprietary hospitals to treat his patients; that provisions of the revised Code prevent him from continuing to treat his patients in proprietary hospitals; and that the revised Code is, therefore, a violation of his constitutional rights.

Plaintiff, Dr. Daly, prior to the adoption of the revised Code, practiced medicine and possessed since 1952, an "S" rating granted by the Workmen's Compensation Board. He complains that the revised code provides that "physicians who hold an 'S' rating granted prior to May 1, 1960, shall submit

to a re-evaluation by these Committees (the Workmen's Compensation Committees of the County Medical Societies of the City of New York) if they desire to be classified as qualified specialists." The complaint also attacks the legality of the provision of the revised code barring licenses for new hospitals unless they are "general" hospitals and unless they have at least 200 beds. It also contains general allegations that the revised code "is vague, uncertain in meaning, impossible to understand, and incomprehensible."

Since none of the plaintiffs has alleged any facts even tending to indicate that he is aggrieved by the license requirement as to numbers of beds or by the restriction of proprietary hospitals to "general" hospitals, they are without standing to obtain an adjudication as to the constitutionality of these provisions.

The allegations that the revised code is vague and incomprehensible must be disregarded, for there is no attempt to specify the respects in which its provisions are vague and unclear and there is nothing to indicate that any of the alleged uncertainties in any way apply to or affect the rights of the three plaintiffs.

Plaintiff Daly's complaint, that he may not validly be required to submit to a re-evaluation of his qualifications in order to retain his "S" rating, has been rendered academic, for it appears that he has submitted himself for such a re-evaluation and that his "S" rating has been reaffirmed.

Plaintiff Cherico's attack upon the present Proprietary Hospital Code proceeds upon the

assumption that its provisions prevent him from continuing to treat his patients at proprietary hospitals as he had done in the past. The complaint does not set forth, except by way of unsupported conclusions, the provisions of the code which Dr. Cherico claims have that effect. It is true, that the code authorizes proprietary hospitals, if they so desire, to maintain a "General Practice Department" (section 14.08[c] Note 2), whose function is to be "administrative and educational only," which is not to be a clinical service and to which no patients are to be admitted (section 15.05[a] and [b]). This does not mean, however, that Dr. Cherico will no longer be able to treat his patients at proprietary hospitals, for section 14.08 of the code makes it mandatory for proprietary hospitals to maintain clinical services for medicine, surgery, anesthesia, laboratories and diagnostic radiology, and also permits additional clinical services to be maintained for various other fields of medicine such as "maternity and newborn," pediatrics, and "physical medicine and rehabilitation." The complaint does not show how the code bars Dr. Cherico from treating his patients on one or more of these clinical services. The moving affidavit of Dr. Trussell, chairman and commissioner of the board of hospitals, states, without contradiction by Dr. Cherico, that the latter's allegation that he is now limited to normal obstetric deliveries "is without basis and is clearly a misunderstanding." Dr. Trussell asserts that "subject to the approval of the Chief of the service on which he wishes to hospitalize a patient and the recommendations of the Credentials Committee of the medical board of each hospital in which Cherico wishes to practice, there is no reason why he should believe that there will be interference with his general prac-

tice." Dr. Trussell points out that even prior to the 1964 amendments to the Proprietary Hospital Code, Dr. Cherico was subject to the supervision of the medical board of each proprietary hospital and was not free to do as he wished without restraint. On the record presently before the court there is no showing that Dr. Cherico is aggrieved by the 1964 amendments to the code.

We come now to Dr. Ferrante, whose grievance is that he cannot continue to perform surgery in proprietary hospitals, as he has done heretofore, because he does not meet the qualifications imposed by the 1964 amendments to the code for physicians authorized to perform major or complicated surgery in such hospitals.

Dr. Ferrante contends that the board of hospitals, which adopted the code, had no power to do so. Section 583(a) of the New York City Charter expressly authorizes the board of hospitals to promulgate and include in the hospital code "necessary rules and regulations to carry out the purposes of this subdivision to protect the public health and welfare." In Engelsher v. Jacobs (5 N.Y.2d 370), a provision of the hospital code, promulgated by the board of hospitals, which imposed a requirement of seventy square feet of floor area for each bed in a private room in a proprietary hospital was upheld as a valid exercise of the police power. The opinion of the court pointed out (p. 374) that "the Legislature itself, in respect to private proprietary hospitals in New York City, has established them in a separate class and has subjected them to special rules and regulations by the Board of Hospitals." The attempt of Dr. Ferrante's counsel to distinguish the Engelsher case (supra), as applicable only to such matters

as bed space, in proprietary hospitals and as inapplicable to such matters as the qualifications of the persons who may perform surgery in such hospitals, appears to this court to be without merit. Section 583-a (supra) of the charter contains no such limitation or any limitation upon the scope of the rules and regulations, except only that they must have as their object the carrying out of the declared purpose "to protect the public health and welfare." In the Engelsher case (supra), the Court of Appeals indicated that the only limitation upon the powers of the board of hospitals to promulgate rules and regulations for proprietary hospitals is that the rules and regulations must be for reasonably "calculated to promote the health and welfare of the public generally." It cannot be gainsaid that regulations as to the qualifications of those who may perform surgery in proprietary hospitals are even more important to the promotion of the public health and welfare than regulations as to the area of floor space required for beds. In Chiropractic Association of New York v. Hilleboe (12 N.Y.2d 109), regulations of the New York Sanitary Code adopted by the Public Health Council, which placed limitations upon X-rays for human beings, were similarly upheld. The court pointed out that the only proper inquiry was whether there was a reasonable basis for the regulations in question.

The moving affidavit of Dr. Trussell points out that studies made prior to the 1964 revision of the hospital code had revealed serious deficiencies in the quality of the medical and surgical services performed in proprietary hospitals and that the situation as to such hospitals was much worse than in the case of municipal and voluntary hospitals. Steps were taken by Dr. Trussell to

improve the medical care in all hospitals under the jurisdiction of the department of hospitals as well as in hospitals that receive city funds to provide adequate care for the indigent sick. To deal with proprietary hospitals, a large advisory committee of experts was appointed and the 1964 revision of the hospital code was the result of more than a year of study by such committee. Dr. Trussell points out that the first three criteria imposed by the code revision for a qualified surgeon at a proprietary hospital are "nationally recognized." He adds that in order to avoid working a hardship on physicians who do not meet any of these criteria, but who through experience and informal training under supervision have acquired the competence of a "qualified surgeon," the Board added two other criteria viz: the holding of the rank of Attending or Associate Attending Surgeon in an accredited voluntary or government hospital during the five year period prior to the adoption of the 1964 provisions of the Code, or the possession of an "S" rating granted by the Workmen's Compensation Committees of the County Medical Societies of New York City on and after May 1, 1960. In view of the uncontroverted facts stated in Dr. Trussell's affidavit regarding the need for improving the quality of medical and surgical care in hospitals, and particularly in proprietary hospitals, the qualifications and requirements imposed by the 1964 revision for permission to perform surgery in proprietary hospitals cannot be deemed unreasonable or arbitrary. On the contrary, they appear to be eminently reasonable and even necessary for the improvement of the deplorable conditions which the studies referred to by Dr. Trussell have revealed.

Nor is there merit to Dr. Ferrante's contention

that the imposition of qualifications for performing surgery at proprietary hospitals which he cannot meet is unconstitutional. Dr. Ferrante, merely by virtue of his license to practice medicine in New York State and his having performed surgery for many years in proprietary hospitals, did not acquire a vested constitutional right to continue to perform surgery in such hospitals. Whatever rights he possessed were subject and subordinate to the right of the appropriate public authorities to require that physicians performing surgery in hospitals possess requirements calculated to protect the public from the dangers of surgery at the hand of incompetent and unqualified practitioners. The provisions of the 1964 revisions to the Code do not violate the due process requirements of the United States Constitution or any of the other constitutional provisions invoked in the complaint.

Dr. Trussell's affidavit points out (paragraph 23 through 25) that Dr. Ferrante and others similarly situated, if they apply to their county medical society for an "S" rating and receive the same will be recognized as "qualified specialists" for the purposes of the Code.

For the reasons indicated, this motion, which is, in effect, one for summary judgment dismissing the complaint, is granted.

AMENDED FINAL ORDER/JUDGMENT OF COURT OF APPEALS

STATE OF NEW YORK, SS:

PLEAS in the Court of Appeals, held at Court of Appeals Hall, in the City of Albany, on the 24th day of March in the year of our Lord one thousand nine hundred and sixty-six, before the Judges of said Court.

WITNESS,

THE HON. CHARLES S. DESMOND,
Chief Judge, Presiding.

RAYMOND J. CANNON, Clerk.

REMITTITUR March 24, 1966.

STATE OF NEW YORK,
IN COURT OF APPEALS

At a Court of Appeals for the State of New York, held at Court of Appeals Hall in the City of Albany on the Fifth day of May A.D. 1966.

P R E S E N T:

HON. CHARLES S. DESMOND,
Chief Judge, presiding.

A motion to amend the remittitur in the above cause having heretofore been made upon the part of the appellants herein and papers having been submitted thereon and due deliberation having been thereupon had, it is

ORDERED, that the said motion be and the same hereby is granted, the return of the re-

mittitur requested and, when returned, it will be amended by adding thereto the following:

> Upon the appeal herein there were presented and necessarily passed upon certain questions under the Constitution of the United States, viz: The appellants contended that the New York City Hospital Code provisions dealing with proprietary hospitals involved an unconstitutional delegation of legislative power in violation of Article I, Section 1, of the Constitution of the United States and of the Ninth, Tenth and Fourteenth Amendments to said Constitution. The appellant Ferrante also contended that the qualifications prescribed in the revised New York City Hospital Code for surgeons practicing in proprietary hospitals deprived him of the right to due process of law and equal protection of the laws under the Fourteenth Amendment, violated the provisions of the Ninth Amendment with respect to rights retained by the People and constituted cruel and unusual punishment under the Eighth and Fourteenth Amendments. The Court of Appeals passed upon such questions and held that there was no violation of the constitutional rights of any of the appellants.

AND the Supreme Court of New York County hereby is requested to direct its Clerk to return said remittitur to this Court for amendment accordingly.

A copy

s/ Gearon Kimball,

Deputy Clerk

No. 469

Amended Final Order/Judgment of Court of Appeals

BE IT REMEMBERED, That on the 4th day of November, in the year of our Lord one thousand nine hundred and sixty-five, Dr. Frank M. Ferrante, & ors., the appellants in this cause, came here unto the Court of Appeals, by Henry Mark Holzer and Edith Packer, their attorneys, and filed in the said Court a Notice of Appeal and return thereto from the order of the Appellate Division of the Supreme Court in and for the First Judicial Department. And The City of New York, & ors., &c., the respondents in said cause, afterwards appeared in said Court of Appeals by Leo A. Larkin, their attorney.

Which said Notice of Appeal and the return thereto, filed as aforesaid, are hereunto annexed.

WHEREUPON, The said Court of Appeals having heard this cause argued by Mr. Henry Mark Holzer, of counsel for the appellants, and by Mr. John F. Kelly, of counsel for the respondents, and after due deliberation had thereon, did order and adjudge that the order of the Appellate Division of the Supreme Court appealed from herein be and the same hereby is affirmed, without costs.

And it was also further ordered, that the records aforesaid, and the proceedings in this Court, be remitted to the Supreme Court of the State of New York, there to be proceeded upon according to law.

THEREFORE, it is considered that the said order be affirmed, without costs, as aforesaid.

And hereupon, as well the Notice of Appeal and return thereto aforesaid as the judgment of

the Court of Appeals aforesaid, by it given in the premises, are by the said Court of Appeals remitted into the Supreme Court of the State of New York before the Justices thereof, according to the form of the statute in such case made and provided, to be enforced according to law, and which record now remains in the said Supreme Court, before the Justices thereof, &c.

s/ Raymond J. Cannon
Clerk of the Court of Appeals
of the State of New York.

COURT OF APPEALS, CLERK'S OFFICE,)
)
Albany, March 24, 1966.)

I HEREBY CERTIFY, that the preceding record contains a correct transcript of the proceedings in said cause in the Court of Appeals, with the papers originally filed therein, attached thereto.

[SEAL]

s/ Raymond J. Cannon
Clerk.

A-13

THE CITY OF NEW YORK

BOARD OF HOSPITALS

HOSPITAL CODE—PART II

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THE HOSPITAL CODE OF THE CITY OF NEW YORK AND REGULATIONS

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BOARD OF HOSPITALS

Corrected Amendments Filed with the City Clerk on August 7, 1964 and Published in THE CITY RECORD on August 11, 12 and 13, 1964.

Corrected Amendments to the Hospital Code

Resolved:

1. Article I Section 1.04 Subdivision (a) of the Hospital Code is hereby amended to read as follows:

"(a) Notwithstanding any other provision contained in this code, where there are practical difficulties or unnecessary hardships in complying with the strict letter of the provisions of this code, the Board shall have the power in a specific case to modify any provisions thereof in harmony with the general purposes and intent of this code."

2. Article I Section 1.04 Subdivision (b) of the Hospital Code is hereby amended to read as follows:

"(b) The Commissioner shall license all existing homes which comply structurally with the minimal standards established by the Board in the "guidelines" which were adopted by it and became effective May 24, 1961 following the repeal of the "grandfather clauses" of the Hospital Code provided that such homes comply with the other requirements applicable thereto."

3. Article I Section 1.04 Subdivision (c) of the Hospital Code is hereby renumbered to be Subdivision (d) and is amended to read as follows:

"(d) Applications for modifications and exceptions provided in this section shall be heard by a Hearing Officer appointed by the Commissioner. The recommendations of the Hearing Officer shall be submitted to the Board of Hospitals."

4. Article I Section 1.04 of the Hospital Code is hereby amended by the addition of a new Subdivision (c) to read as follows:

"(c) The Board shall establish guidelines as a basis for application of this code to existing homes and hospitals which do not comply with the provisions of this code.

The requirements of this code shall not apply to existing homes and hospitals until guidelines are adopted and a calendar of implementation of such guidelines is established and distributed to all existing homes and hospitals."

5. Article III Sections 40 through 55 inclusive, Section 56 Subdivision 1, 2, 3, 5, 6, 7, 8, 9, 10 and Section 57 of the Hospital Code are hereby repealed.

6. Article XII of the Hospital Code is hereby renumbered to be Article XVII.

7. The Hospital Code is hereby amended by the addition of new Articles XI and XIII through XVI to read as follows:

HOSPITAL CODE, PART II—PROPRIETARY HOSPITALS

(New Article XII is not contained herein)

PART II—PROPRIETARY HOSPITALS

ARTICLE XI LICENSURE

SECTION

11.01 SPECIFIC DEFINITIONS.
11.02. LICENSURE—GENERAL PROVISIONS.
11.03. PRELIMINARY APPROVAL.
11.04. APPLICATION FOR AN INITIAL TEMPORARY LICENSE.
11.05. LICENSED BED CAPACITY.
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11.07. ISSUANCE OF LICENSE TO A NEW HOSPITAL.
11.08. ACCREDITATION.
11.09. RENEWAL OF LICENSE.
11.10. REVOCATION OR NON-RENEWAL OF A LICENSE.
11.11. RETURN OF LICENSE.
11.12. RELOCATION OF PATIENTS UPON CLOSURE OF A HOSPITAL.

§ 11.01. Specific Definitions

When used in this code, unless otherwise expressly stated or unless the context or subject matter requires different interpretation, the following definitions shall apply:

(a) A "proprietary hospital" or "hospital" shall be held to mean an institution operated for the purpose of providing therein, for profit, services, facilities and beds for two (2) or more in-patients, not related to the licensee, who require diagnosis, treatment

or care for illness, injury, deformity, infirmity or pregnancy, where such patients are kept for twenty-four (24) or more consecutive hours; and which may include facilities for ambulatory patients who require diagnosis, treatment or care for illness, injury, deformity, infirmity or pregnancy.

(1) A new hospital shall be held to mean:
  (a) A hospital which was never licensed prior to *July* 1, 1964 or
  (b) A hospital which was licensed and in operation prior to *July* 1, 1964 but whose license has been finally revoked, or
  (c) A hospital which discontinued its operation for any reason whatsoever prior to *July* 1, 1964

(2) An existing hospital shall be held to mean:
  (a) An operating hospital whose license has not been revoked by the Commissioner by *July* 1, 1964
  (b) A hospital which is under construction according to plans reviewed by the Commissioner and approved by the Department of Buildings prior to *July* 1, 1964, provided that such construction is completed prior to *July* 1, 1965

(b) A general hospital shall be held to mean a proprietary hospital which provides, as a minimum, general medical and surgical services.

(c) A special hospital shall be held to mean a proprietary hospital which limits its services to one (1) particular specialty.

(d) An accredited hospital shall be held to mean a hospital which has been accredited by the Joint Commission on Accreditation of Hospitals, or an osteopathic hospital which has been accredited by the Committee on Hospitals of the American Osteopathic Association.

(e) "License" shall be held to mean a license duly issued by the Commissioner to operate a hospital.

The following licenses shall be issued as indicated:

(1) Initial license is a temporary license issued for a period of ninety (90) days to a new hospital or a new licensee.

(2) Annual license is a license issued for one (1) year to a hospital found on inspection to be in substantial compliance with this code.

(3) Provisional license is a license issued for not less than thirty (30) days for specified non-compliance with this code.

(f) "Applicant" shall be held to mean a person or persons who intend to operate and be responsible for a hospital and who submit to the Commissioner an application for a license to operate a hospital. The applicant may not be a limited partnership or corporation except that individuals and/or corporations which have been continuously operating hospitals licensed by the Department may be applicants for licensure of the same hospital. (see Section 35-b of the Social Welfare Law)

(g) "Licensee" shall be held to mean the person, persons, or duly authorized corporations to whom the Commissioner has issued a license to operate a hospital in compliance with the provisions of this code.

(h) "Patient" shall be held to mean any person receiving care in a hospital.

(i) "Sponsor" shall be held to mean the person, persons or agency legally responsible for the welfare and support of a patient.

(j) "Qualified hospital administrator" shall be held to mean a person who:

(1) Has at least a master's degree in Hospital Administration, Administrative Medicine or a Master of Public Health degree when conferred for a course in hospital administration. Such degrees shall have been awarded in university programs which are members of the Association of University Programs of Hospital Administration. The course of study shall include satisfactory completion of either two (2) academic years or one (1) academic year plus one (1) year of approved residency in hospital administration or any satisfactory combination of these as determined by the university, including a residency equivalent allowance, or

(2) Has successfully completed a high school education or its educational equivalent and has served for five (5) years as an Administrator, Assistant or Associate Administrator in an accredited hospital, or has had similar experience in health agency administration acceptable to the Commissioner, or

(3) Has a bachelor's degree or is a doctor of medicine or registered professional nurse or has an equivalent degree from a recognized college or university, including, or supplemented by, some formal training in hospital or business administration, and has had a minimum of three (3) years responsible experience as an Administrator, Assistant or Associate Administrator, or Assistant or Associate Director of an accredited hospital.

(4) In addition to the requirements stated herein, a doctor of osteopathy may serve as the qualified administrator of an osteopathic hospital.

(k) "Qualified internist" shall be held to mean a physician who holds a current license to practice medicine in the State of New York and who:

(1) Is a Diplomate of the American Board of Internal Medicine, or

(2) Is a Fellow of the American College of Physicians, or

(3) Has been notified of admissibility to examination by the American Board of Internal Medicine, or presents evidence of completion of a residency in Internal Medicine approved by the American Medical Association, or

(4) Holds the rank of Attending or Associate Attending Physician in an accredited voluntary or governmental hospital or has held either of these ranks during the five (5) years prior to the adoption of this code.

(l) "Qualified surgeon" shall be held to mean a physician who holds a current license to practice medicine in the State of New York and who:

(1) Is a Diplomate of the American Board of Surgery, or

(2) Is a Fellow of the American College of Surgeons, or

(3) Has been notified of admissibility to examination by the American Board of Surgery, or presents evidence of completion of a residency in Surgery approved by the American Medical Association, or

(4) Holds the rank of Attending or Associate Attending Surgeon in an accredited voluntary or governmental hospital or has held either of these ranks during the five (5) years prior to the adoption of this code.

(m) "Qualified obstetrician" shall be held to mean a physician who holds a current license to practice medicine in the State of New York and who:

(1) Is a Diplomate of the American Board of Obstetrics and Gynecology,

(2) Is a Fellow of the American College of Surgeons, in the specialty of obstetrics and gynecology, or

(3) Has been notified of admissibility to examination by the American Board of Obstetrics and Gynecology, or presents evidence of completion of a residency in obstetrics and gynecology approved by the American Medical Association, or

(4) Holds the rank of Attending or Associate Attending Obstetrician in an accredited voluntary or governmental hospital or has held either of these ranks during the five (5) years prior to the adoption of this code.

(n) "Qualified ophthalmologist" shall be held to mean a physician who holds a current license to practice medicine in the State of New York and who:

(1) Is a Diplomate of the American Board of Ophthalmology, or

(2) Has been notified of admissibility to examination by the American Board of Ophthalmology, or presents evidence of completion of a residency in ophthalmology approved by the American Medical Association, or

(3) Holds the rank of Attending or Associate Attending Ophthalmologist in an accredited voluntary or governmental hospital or has held either of these ranks during the five (5) years prior to the adoption of this code.

(o) "Qualified orthopedist" shall be held to mean a physician who holds a current license to practice medicine in the State of New York and who:

(1) Is a Diplomate of the American Board of Orthopedic Surgery, or

(2) Has been notified of admissibility to examination by the American Board of Orthopedic Surgery, or presents evidence of completion of a residency in orthopedic surgery approved by the American Medical Association, or

(3) Holds the rank of Attending or Associate Attending Orthopedist in an accredited voluntary or governmental hospital or has held either of these ranks during the five (5) years prior to the adoption of this code.

(p) "Qualified pediatrician" shall be held to mean a physician who holds a current license to practice medicine in the State of New York and who:

(1) Is a Diplomate of the American Board of Pediatrics, or

(2) Has been notified of admissibility to examination by the American Board of Pediatrics, or presents evidence of completion of a residency in Pediatrics approved by the American Medical Association, or

(3) Holds the rank of Attending or Associate Attending Pediatrician in an accredited voluntary or governmental hospital or has held either of these ranks during the five (5) years prior to the adoption of this code.

(q) "Qualified anesthesiologist" shall be held to mean a physician who holds a current license to practice medicine in the State of New York and who:

(1) Is a Diplomate of the American Board of Anesthesiology, or

(2) Is a Fellow of the American College of Anesthesiology, or

(3) Has been notified of admissibility to examination by the American Board of Anesthesiology, or presents evidence of completion of a residency in Anesthesiology approved by the American Medical Association, or

(4) Holds the rank of Attending or Associate Attending Anesthesiologist in an accredited voluntary or governmental hospital or has held either of these ranks during the five (5) years prior to the adoption of this code.

(r) "Qualified pathologist" shall be held to mean a physician who holds a current license to practice medicine in the State of New York and who:

(1) Is a Diplomate of the American Board of Pathology for anatomical and/or clinical pathology, or

(2) Is a Fellow of the American College of Pathology, or

(3) Has been notified of admissibility to examination by the American Board of Pathology, or presents evidence of completion of a residency in Pathology approved by the American Medical Association, or

(4) Holds the rank of Attending or Associate Attending Pathologist in an accredited voluntary or governmental hospital or has held either of these ranks during the five (5) years prior to the adoption of this code.

(s) "Qualified roentgenologist" shall be held to mean a physician who holds a current license to practice medicine in the State of New York and who:

(1) Is a Diplomate of the American Board of Radiology, or

(2) Is a Fellow of the American College of Radiology, or

(3) Has been notified of admissibility to examination by the American Board of Radiology, or presents evidence of completion of a residency in Radiology approved by the American Medical Association, or

(4) Holds the rank of Attending or Associate Attending Roentgenologist in an accredited voluntary or governmental hospital or has held either of these ranks during the five (5) years prior to the adoption of this code.

In osteopathic hospitals, a qualified specialist shall be held to mean a doctor of osteopathy who holds a current license to practice medicine in the State of New York and who:

(1) Has been certified as a specialist by the American Osteopathic Specialty Board for the respective specialty, or

(2) Has been notified of admissibility to examination by an American Osteopathic Board, or presents evidence of completion of a residency in the respective specialty.

Such qualified specialist recognition shall be limited to osteopathic hospitals.

A qualified specialist shall be held to mean a physician who holds an "S" rating granted by the Workman's Compensation Board of the State of New York as a result of recommendation by the Workman's Compensation Committees of the County Medical Societies of the City of New York on and after May 1, 1960. Physicians who hold an "S" rating granted prior to May 1, 1960, shall submit to a re-evaluation by these Committees if they desire to be classified as qualified specialists.

(t) "Qualified radiation therapist" shall be held to mean a physician who holds a current license to practice medicine in the State of New York and who:

(1) Is a Diplomate of the American Board of Radiology, or Roentgentherapy, or

(2) Has been notified of admissibility to examination by the American Board of Radiology, or presents evidence of completion of a residency in Radiology or Roentgentherapy approved by the American Medical Association, or

(3) Holds the rank of Attending or Associate Attending Radiation Therapist in an accredited voluntary or governmental hospital or has held either of these ranks during the five (5) years prior to the adoption of this code.

(u) "Qualified radiation physicist" shall be held to mean a graduate physicist who has been certified by the American Board of Radiology as a qualified radiation physicist.

Qualified specialists in other fields of medicine shall be recognized according to the same type of criteria listed above in paragraphs (k) through (s) as approved by the Commissioner.

(v) "Registered professional nurse" or "registered nurse" shall be held to mean a nurse who holds a current license issued by the Department of Education of the State of New York to practice as a registered professional nurse and who has registered with such department, in accordance with the provisions of the Education Law.

(w) "Licensed practical nurse" or "practical nurse" shall be held to mean a nurse who holds a current license issued by the Department of Education of the State of New York to practice as a licensed practical nurse and who has registered with such department, in accordance with the provisions of the Education Law.

(x) "Qualified nutritionist" or "nutritionist" shall be held to mean a person who:

(1) Has been graduated from an institution of learning approved by the Department of Education of the State of New York, and

(2) Holds a bachelor's degree in home economics including major studies in foods, nutrition or institutional management and has had at least two (2) years experience as a nutritionist in a health or welfare agency, or

(3) Has received a master's degree in nutrition from such an institution [redacted] had at least one (1) year experience as a nutritionist in a health or welfare agency, or

(4) Has had the equivalent of such post-graduate training and experience as approved by the Commissioner.

(y) "Qualified dietitian" or "dietitian" shall be held to mean a person who:

(1) Has graduated from an institution of learning approved by the Department of Education of the State of New York, and

(2) Holds a bachelor's degree in home economics including major studies in foods, nutrition or institutional management, and

(3) Has had an internship as a dietitian in an institution approved by the American Dietetics Association,

(4) Has had the equivalent of such post-graduate training and experience as approved by the Commissioner.

(z) "Licensed physical therapist" shall be held to mean any person who holds a current license issued by the Department of Education of the State of New York to practice as a physical therapist and who has registered with such Department in accordance with the provisions of the Education Law.

(aa) "Qualified social worker" shall be held to mean any person who has a master's degree or certificate after successfully completing a two (2) year course of study at a graduate school of social work accredited by the Council on Social Work Education or an equivalent as accepted for membership in the National Association of Social Workers and accredited by the Department of Education of the State of New York.

§ 11.02. **Licensure—General Provisions**

(a) No person or persons shall maintain or operate a hospital without a current license.

(b) A license shall not be issued for the operation of a new hospital which is not a general hospital.

(c) A license shall not be issued for the operation of a new hospital which contains less than two hundred (200) beds.

(d) A license shall indicate the bed capacity and the types of services for which it is issued.

(e) A license to operate a hospital shall be issued by the Commissioner to a particular individual or individuals and for the designated place of business mentioned in the license. The license shall not be valid for use by any other person or persons, or at any place other than that designated in the license. Any transfer as to person or place shall cause an immediate forfeiture of such license.

(f) A license issued by the Commissioner shall expire one (1) year from the date of issuance or upon such dates annually as he may prescribe. Notwithstanding any provision of this code the Commissioner may issue a provisional license for a period not less than thirty (30) days for specified non-compliance with this code.

(g) The license shall be posted conspicuously on the licensed premises.

(h) Before an initial temporary license will be issued, a hospital shall file with the Commissioner a copy of its current certificate of occupancy and a current electrical certificate issued by the Department of Water Supply, Gas and Electricity.

(i) An applicant must be a physician currently licensed to practice medicine or osteopathy in the State of New York, over the age of twenty-one (21) years; a citizen of the United States or a person who has declared his intention of becoming a citizen; a resident of New York State; of reputable character; financially responsible; and who has not had a license to operate a hospital revoked or not renewed for cause. Notwithstanding the foregoing, a partnership of such physicians may include not more than one (1) dentist currently licensed to practice dentistry in the State of New York. Each applicant shall furnish such other and further pertinent information as is indicated in the application or required by the Commissioner. Each applicant shall authorize the Commissioner to investigate and verify the information submitted to support the application for licensure.

(j) The applicant shall furnish the Commissioner with an accurate copy of all leases and agreements entered into by the applicant pertaining to the ownership and/or operation of the hospital in addition to all agreements relating to the distribution of gross or net income derived from the operation of the hospital. All proposed changes in said agreements or proposed agreements pertaining to the aforesaid shall be submitted in writing to the Commissioner not less than thirty (30) days prior to execution.

(k) The Commissioner or his designated representative shall, at all times, have the right to inspect and investigate a hospital and all records pertaining thereto. They shall,

at all times, have the right, under appropriate legal and professional safeguards, to direct the examination of patients, inspect patients' medical records and conduct medical audits in order to evaluate the quality of the medical care being provided in a hospital.

(l) The Commissioner shall be notified in writing not less than thirty (30) days before changes in ownership, physical plant or name of a hospital and immediately on change in bed capacity or any known or pending change in management. If the licensee is a corporation, the Commissioner shall be notified in writing not less than thirty (30) days before changes are made in the record ownership of the stock of said corporation together with detailed information concerning the prospective recipient thereof.

NOTE: Upon the death or incompetency of a licensee, the Commissioner will issue a provisional license to the legal representative(s) of the deceased licensee for a reasonable period to permit proper disposition of the deceased licensee's interest in such hospital. If, upon death or incompetency of a co-licensee, his interest in a hospital is transferred to co-licensee(s) the Commissioner will issue to the co-licensee(s) a license of the same type and with the same expiration date as in effect at the date of death of the deceased co-licensee provided, however, that the remaining licensee(s) has sufficient funds in cash to continue the operation of the hospital proper.

§ 11.03. Preliminary Approval

Any person who wishes to construct a new hospital or to erect an addition to an existing hospital or to reconstruct a building or buildings for the purpose of operating a hospital therein shall obtain the approval of the Commissioner for the location and for the preliminary plans thereof.

Before giving his approval the Commissioner shall submit such requests to the Hospital Review and Planning Council of Southern New York for their recommendation as to the public need for the proposed construction, addition or modification.

If the decision of the Commissioner is contrary to the recommendation of the Hospital Review and Planning Council of Southern New York, he shall hold a public hearing prior to making a final determination.

NOTE: Before any person or persons enter into any negotiations or commitments having to do with the purchase of an existing hospital or the acquisition of a site for the construction of a new hospital or the erecting of an addition to an existing hospital or the reconstruction of a building or buildings for the purpose of operating a hospital therein, he should avail himself of the information services of the Department.

§ 11.04. Application for an Initial Temporary License

(a) An applicant for a license to operate a hospital shall file with the Commissioner an application on an official form which will be furnished by the Commissioner. The application shall contain the name, address and occupation of each person, persons, entity or entities who will receive or who will be entitled to receive directly or through a designee, any pecuniary profit from the operation of the hospital, other than compensation for services rendered.

Such application, except as otherwise provided in this code, shall show that the applicant and all persons having a proprietary interest in the operation of the hospital are qualified for licensure and are residents of the State of New York and able to comply with the orders of the Commissioner and the minimum standards established by this code.

(b) In addition, the applicant shall submit the following:

(1) A complete set of preliminary floor plans and preliminary specifications for the building, and such portions of the working drawings as the Commissioner may require. In the case of an existing building, a complete set of floor plans showing present conditions and proposed alterations plus preliminary specifications for proposed alterations.

(2) Plans and specifications required herein shall be accurate and detailed and shall show dimensions of usable clear space; location and type of all departments and services; location and specifications of all fixed equipment (Group I). Location and specifications of beds and other non-fixed equipment (Group II) shall be shown only for prototype patient bedrooms i.e. one (1) bed, two (2) bed, etc. A copy of the plans of the radiological, isotope, maternity and newborn services shall also be filed with the New York City Department of Health. Any proposed changes from the original plans submitted shall be submitted in writing to the Commissioner for his approval. Any revisions affecting the function of the proposed facility and required by the Department of Buildings shall be resubmitted to the Commissioner for approval. All building plans and specifications required to be submitted to the Commissioner shall be prepared by an architect or a professional engineer duly licensed by the State of New York.

(3) A table of organization which shall delineate the various services, their responsibility and their relationship to one another.
(4) The name and qualifications of the Administrator.
(5) The names and qualifications of the members of the Medical Board.
(6) The names and qualifications of the directors of the clinical and ancillary services.
(7) The bed capacity.
(8) The types of medical services which are to be furnished.
(9) The name by which the hospital shall be known.

(c) The applicant shall furnish proof of compliance with all existing laws and regulations applicable to hospitals.

(d) Plans for the construction of a new hospital or the erecting of an addition to an existing hospital or the reconstruction of a building or buildings for the purpose of operating a hospital therein which were filed with the Department and approved by the Department of Buildings prior to July 1, 1964 shall be void unless construction has been completed by January 1, 1966. Such plans shall comply with the standards of this code as they are applied to existing hospitals.

NOTES: Equipment is classified in three groups; the basis of classification being the usual methods of purchase and suggested accounting practices in regard to depreciation.

Group I equipment is that which is usually included in the construction contract. Examples are hospital cabinets and counters, elevators, boilers and other "built-in" equipment.

Group II equipment is depreciable equipment of five years' life or more not normally purchased through construction contracts, such as large items of furniture and equipment having a reasonably fixed location in the building, but capable of being moved. Examples are furniture, surgical apparatus, diagnostic and therapeutic equipment, office machines, laboratory and pharmacy equipment and wheeled equipment.

Group III equipment includes items which have a life of less than five (5) years, normally purchased through other than construction contract. These are items of small cost and suited to storeroom control. Examples are chinaware, silverware, kitchen utensils, bedside lamps, waste baskets, bedpans, dressing jars, catheters, surgical instruments, linens, sheets and blankets.

§ 11.05. Licensed Bed Capacity

Each hospital shall apply for a license to operate a specified number of beds. This shall be known as the licensed bed capacity and shall be as approved by the Commissioner. If at any time the licensee wishes to reduce the licensed bed capacity, he shall advise the Commissioner that he will operate with a specified reduced number.

All beds or part thereof which represents the difference between the licensed bed capacity and the reduced number of beds may be retained in readiness, according to a plan approved by the Commissioner. If the hospital has an annual or provisional license, patients may be admitted at any time to those beds held in readiness subject to the following conditions:

(a) Employment of additional personnel so as to service all patients properly.

(b) Written notification to the Department postmarked within twenty-four (24) hours of admission of patients in excess of the previously stated reduced number of beds, giving the location of such beds in the hospital and the number of additional personnel employed in accordance with provision (a) of this section.

§ 11.06. Application for Modification of an Existing Hospital

Proposed changes in existing hospitals, such as changes in the name of the hospital, physical plant, bed capacity, the names and qualifications of the members of the Medical Board, or extent and type of services provided shall be submitted in writing on forms supplied by the Commissioner. Such changes shall not be made until the receipt of written approval from the Commissioner.

§ 11.07. Issuance of License to a New Hospital

After it has been determined that the applicant has complied with the requirements of the Department and the Commissioner has received and taken into consideration the recommendation of the Hospital Review and Planning Council of Southern New York, he may in his discretion issue a temporary license which shall expire not more than ninety (90) days from the date of issuance. If the hospital has been maintained and operated during this period of temporary licensure in compliance with the provisions of this code the Commissioner shall issue a regular annual license.

§ 11.08. Accreditation

(a) Existing hospitals. All existing hospitals shall achieve accreditation by January 1, 1965. Such accreditation shall be by the Joint Commission on Accreditation of Hos-

pitals or, in Osteopathic hospitals, by the Committee on Hospitals of the American Osteopathic Association.

(b) New Hospitals. All new hospitals shall achieve accreditation as soon as they can be surveyed by the Joint Commission on Accreditation of Hospitals or, in Osteopathic hospitals, by the Committee on Hospitals of the American Osteopathic Association.

(c) The Commissioner shall be notified in writing within seven (7) days of notice of failure to be re-accredited or of loss of accreditation.

§ 11.09. Renewal of License

Two (2) months prior to the expiration date of the annual license, an application for a renewal thereof shall be submitted to the Department on forms supplied by the Department. Upon receipt and review of the application and determination of the extent of compliance with the requirements of the Department, the Commissioner may issue:

(a) A regular annual license, or
(b) A provisional license.

§ 11.10. Revocation or Non-Renewal of a License

The Commissioner may revoke or refuse to renew a license after a hearing and determination thereon.

(a) Grounds for revocation or non-renewal:
  (1) Failure to comply with federal, state and municipal laws, ordinances, standards, sanitary codes, and other codes, rules and regulations and orders applicable to hospitals.
  (2) Conduct of a hospital in a manner deemed by the Commissioner to be detrimental to the health, safety or welafe of patients, employees or the public.
  (3) The licensee's conviction of a crime.
  (4) Misrepresentation of a material fact by the licensee or his authorized representative.
  (5) Loss of accreditation by the appropriate accrediting agency.
  (6) Failure to give any notice concerning change of ownership as required by this code.

(b) Notice of revocation or non-renewal. The Commissioner may revoke or refuse to renew a license for cause only after the licensee has been given an opportunity to be heard on the proposed revocation or non-renewal. The licensee shall be given notice in writing of such proposed revocation or non-renewal and the reasons therefor.

(c) The notice of hearing of proposed revocation or non-renewal of license shall be given at least ten (10) days before the hearing. The notice shall contain the date, time and place of said hearing. The notice shall be personally served on the licensee or when sent in writing by certified or registered mail to the licensee at the hospital or delivered there personally shall be deemed to be sufficient service of such notice. Such notice of hearing of proposed revocation of a license may be given not less than twenty-four (24) hours before a hearing if the Commissioner determines that the operation of a hospital presents imminent peril to the health and well being of the patients in that hospital. The licensee may be represented by counsel at such hearing.

(d) Revocation or non-renewal. Upon revocation or non-renewal of the license, written notice thereof shall be given to the licensee by personal service or sent to the hospital by registered or certified mail.

(e) Review of revocation or non-renewal by the Board. The licensee may upon revocation or non-renewal of a license, within ten (10) days after such decision, file in writing with the Secretary of the Board a request that the Board review the Commissioner's action. However, when a twenty-four (24) hour notice of hearing has been served on the licensee in accordance with subdivision (c) hereof, the licensee may upon revocation or non-renewal of his license file, within forty-eight (48) hours, in writing with the Secretary of the Board a request that the Board review the Commissioner's action. The Board shall, as soon thereafter as possible, review the facts and the Commissioner's decision. The Board may affirm, reverse or modify the Commissioner's determination. The licensee shall be informed in writing of the Board's action. However, an appeal to the Board of Hospitals from the Commissioner's determination, as provided herein, shall constitute a stay thereof for a period of ten (10) days after the Board's decision on said appeal unless said Board directs otherwise.

(f) Notice of revocation or non-renewal, when it becomes final, shall be given to the Medical Society of the county in which the hospital is located, the State Department of Social Welfare, The State Education Department, Division of Professional Conduct, the Hospital Review and Planning Council of Southern New York, the Greater New York Hospital Association, the Associated Hospital Service of Greater New York, the Association of Private Hospitals, the Department of Health, and/or to the public through the press or otherwise. The patients, their nearest of kin or

sponsors and the medical staff of a hospital may be informed of revocation or non-renewal immediately after determination by the Commissioner.

§ 11.11. Return of License

Upon the revocation or expiration of a license, it shall be immediately removed from public view and promptly surrendered to the Department.

§ 11.12. Relocation of Patients Upon Closure of a Hopsital

When the Commissioner has directed, after a hearing, that a hospital discontinue operation or has directed an immediate forfeiture of license as provided in Section 11.02(e), the patients in residence shall be discharged or transferred to other appropriate facilities not later than the date set by the Commissioner. Such discharges or transfers shall be effected by the licensee in consultation with the patients, their nearest of kin or sponsors, their physicians and the Department.

ARTICLE XIII ADMINISTRATION AND MANAGEMENT

Section

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§ 13.01. Licensee

The licensee shall be responsible for the establishment of policy; for the quality of medical services; for the general management and operation; for the maintenance of the physical plant and equipment; for the care and safety of the patients; for the employment of sufficient licensed and other qualified personnel; for personnel policies and practices, and business management of the institution.

§ 13.02. Administration

(a) Administrative responsibility. The licensee shall employ a qualified hospital administrator. The administrator shall be responsible at all times for directing, co-ordinating and supervising the administration of the hospital to insure compliance with all applicable federal, state and city laws, as well as the rules and regulations established by the Medical Board. The administrator shall provide liaison between the licensee, the medical staff, the nursing staff, and other departments of the hospital.

(b) Full time. The administrator shall devote full time to the management of the hospital. During periods of absence of the administrator, the licensee shall provide administrator coverage and notify the Department thereof.

§ 13.03. Staffing

(a) Staffing. The licensee shall provide at all times, a staff having satisfactory qualifications and the ability to carry out the responsibilities as defined in this code.

(b) The number of personnel in each category shall be based on the bed complement, the physical layout of the hospital and the types of services offered therein.

(c) Provision shall be made for relief personnel during days off, vacation, sick leave and periods of emergency.

(d) All persons shall be on active duty at their respective stations during their tours of duty, unless relieved.

§ 13.04. Selection and Training of Personnel

Personnel shall be selected for their experience, ability and interest in working with hospital patients. They shall receive an orientation to their jobs and to the operation of the hospital. On-the-job training shall be the responsibility of the appropriate department heads.

§ 13.05. Personnel Policies

(a) Personnel Policies. The hospital shall have available a written statement of personnel policies, including therein a table of organization, job descriptions, salary levels, roster of positions authorized and filled, authorization for the filling of vacancies as needed, and in-service training programs and written policies covering paydays, vacations, holidays, overtime, hospitalization and retirement benefits, leaves of absence, health and accident benefits, and pre-employment and employment physical examinations,

provisions for emergency care, communicable disease control and maintenance of health standards for all personnel.

(b) Job descriptions. The licensee shall have available a written job description for all key positions, including that of the administrator, setting forth the responsibilities, the degree of vested authority, authority for hiring or firing of staff, for implementation of medical staff policies, for business management and public relations.

(c) Health for personnel.

(1) Medical examinations of all personnel shall be made at no expense to the employees.

(2) Medical examinations shall be given upon employment or immediately thereafter as well as annually and whenever necessary to ascertain that employees are free of communicable disease.

(3) Medical examination records shall be kept on file and shall be available for inspection.

§ 13.06. Records and Reports

The following documents and references shall be on file in the hospital and shall, at all times, be available for inspection by the Commissioner or his designated representative:

(a) By-laws of the medical staff.

(b) Minutes of committee meetings and committee reports.

(c) Applications for all current medical, technical and professional staff members containing qualifications and supporting documents (including satisfactory evidence of conformity with requisite professional licensing laws.)

(d) All leases and agreements entered into by the licensee pertaining to the ownership and/or operation of the hospital and to the distribution of gross income or net income.

(e) Results of all recent inspections of the hospital by the Department of Hospitals, other city regulating departments and accrediting agencies.

(f) All necessary licenses, permits and certificates for the operation of the hospital and for certain departments and for staff members when required. Certificates shall be framed in accordance with official requirements.

(g) Admission register, operation record book, patient register, birth record register, daily census record, death and accident register. The accident register shall contain all information concerning accidents to patients, employees and visitors.

(h) The record of hospital acquired infections and the record of diseases and conditions reported to the Health and Police Departments, Medical Examiner or other regulating agencies.

(i) Patients' account records.

(j) Dietary record. The dietary record shall consist of the regular daily menus for meals prepared for at least the thirty (30) days preceding.

(k) Fire drill records. The fire drill records shall have recorded the date, hour, description of the drill and personnel who participated in fire drills. These records shall be kept for at least one (1) year.

(l) Personnel records. Personnel records shall be maintained for all employees and shall include the following: references and records of professional licenses and registrations; records of physical examinations and all chest X-rays, time cards, payroll records, dates of employment, resignation and dismissal and other pertinent data.

§ 13.07. Responsibility for Medical Staff and Medical Services

(a) The licensee shall consult the Medical Board in all matters pertaining to medical care.

(b) The licensee shall establish a formal means of liaison with the medical staff by means of a Joint Conference Committee.

(c) The licensee shall not appoint a physician to the medical staff without the recommendation of the Medical Board.

(d) The licensee shall approve the by-laws or rules and regulations of the medical staff and any revisions thereof.

(e) The licensee shall furnish the Commissioner with a copy of the medical staff by-laws and any revision thereof.

§ 13.08. Accounting and Finance

(a) The licensee shall be responsible for the maintenance of an accounting system and records which will accurately reflect in detail all assets, liabilities and net worth. These financial records shall be available at all time for inspection by the Commissioner.

(b) Audit requirements. The books and records of the hospital shall be examined annually by an independent public accountant. These books, records and reports shall be available to the Commissioner on specific request.

(c) Charges. A consolidated schedule of current charges for all services shall be maintained by the hospital. Copies of all proposed charges and changes in the schedule of charges shall be available for review.

(1) Hospitals shall not make unreasonable or unwarranted charges for services rendered.

(2) Patients shall not be prevented from leaving a hospital because bills either for the hospital or a physician are unpaid.

(3) Prepayment and refunds. When payment for hospital services or care has been made in advance, a refund of the excess of the prepayment shall be made promptly.

(4) Hospitals shall bill only for services ordered or approved by the patient's attending physician and rendered to the patient. The term "services" as used in this subdivision shall include room charge, drugs, medication and all other items for which the patient is required to pay.

(5) An all-inclusive per diem rate may be charged for hospitalization provided said all-inclusive rate does not contain fees for the services of the attending private physician. Bills for hospitalization shall itemize all services and charges even when they contain an all-inclusive per diem rate.

§ 13.09. **Admission Policies**

(a) The licensee shall establish and provide the admitting office with written admission and discharge policies. Such specific policies shall encompass the following: Types of clinical conditions of patients to be admitted together with limitations imposed by law, licensure, physical limitations, staffing limitations, rules governing emergency admissions. Policies concerning advance deposits, insurance agreements and other financial considerations, discharge of patients, medical information service and other relevant functions.

(b) Except in emergencies, patients shall be admitted only upon referral and under the care of a currently licensed physician or dentist who shall be a member of the staff of the hospital. The patient's condition and provisional diagnosis shall be established on admission by the patient's physician or the physician in residence who admits the patient.

(c) Except in emergencies a hospital shall admit as patients only those persons who require the type of medical services for which the hospital has been licensed.

(d) Medical Admitting Officer. The hospital shall have on the premises at all times a physician currently licensed in New York State, who shall be responsible for receiving patients for care under the established written policies of the hospital, or to make other appropriate disposition.

(e) Communicable disease. Insofar as it is practicable, the admitting physician shall request of each person applying for admission, information concerning signs or symptoms of or recent exposure to communicable disease. Whenever there are positive findings, the patient shall be isolated pending an appropriate disposition. When patients are admitted with communicable diseases or when a communicable disease is diagnosed after admission, such patients shall be isolated and the hospital shall comply with the requirements of the New York City Health Code in respect to the care of such patients.

(f) Safety precautions. Reasonable precautions shall be taken in all admissions for the safety of other patients.

(g) Non-discrimination No person shall be denied admission to the hospital because of his race, creed, color or national origin.

(h) Patient's record of admission and discharge. A complete and permanent record shall be maintained of all patients admitted, including but not limited to the date, time, the name, address, date of birth, the nearest of kin or sponsor, insofar as these are obtainable, the provisional diagnosis, condition, the name of the referring physician, the hospital attending physician or service and, as to discharge, the date and time, condition and final diagnosis.

(i) Admission history and examination. Within twenty-four (24) hours after admission, every patient shall have a complete history and physical examination performed by a physician. Within this period of time, the patient's private physician shall also have completed in writing the proper medical history and physical examination forms indicating his findings, diagnosis, course of treatment, and his indorsement or modification of the resident physician's history, examination and diagnosis, if any.

(j) Detaining of patients. No mentally competent adult shall be detained in a hospital against his will, nor shall a minor be detained against the will of his parent or legal guardian. This restriction shall not be construed to preclude or prohibit the persuasion of the patient in his own interest, nor the temporary detention of a mentally disturbed patient for the protection of himself or others, pending prompt legal disposition, nor a person who has been legally committed to a hospital.

(k) Transfer or discharge of patients. No patient shall be transferred or discharged for purposes of effecting a transfer from a hospital unless arrangements have

been made for admission to another appropriate health facility. A transfer or discharge shall not be carried out if in the opinion of the patient's physician, such transfer or discharge would create a medical hazard.

(l) Discharge of minors. A minor shall be discharged only in the custody of his or her parent, or a member of the immediate family of the patient or legal guardian or custodian.

(m) Release of dead bodies. A dead body, including a stillborn infant or foetus estimated by an attending physician to have completed sixteen (16) weeks of gestation, shall be delivered only to a licensed undertaker or to an agent authorized by law to receive the body.

§ 13.10. Personal Gain and Rebating

Rebating prohibited. Licensees or their representatives shall not pay directly or indirectly, a commission, bonus or gratuity in any form whatsoever to a physician, person, organization or agency for referral of patients.

§ 13.11. Fire Prevention, Fire Drills and Evacuation

(a) Master plan. The administrator or his designee shall develop a master fire plan to fit the needs of the hospital. In addition to the regulations of the Fire Department of The City of New York, programs for the prevention of fire and protection of patients in the event of fire or other catastrophes shall be available in writing. The institution's personnel shall be fully informed concerning such programs.

(b) Fire drill.

(1) Employees shall be trained by means of staff fire drills in the use of fire-fighting equipment and the means of rapidly evacuating the hospital.

(2) Drills shall be held at least once a month at varied times during the day and night hours, and a record shall be kept of all drills.

(3) The Administrator shall designate employees for each working tour to provide continuous coverage to perform the duties concerned with fire drill and evacuation procedures as outlined in the fire prevention program of the hospital. Such a program shall include a chart which indicates fire stations and positions. These charts shall be kept up to date and posted in a conspicuous place on each floor.

(c) Fire extinguishers.

(1) They shall be provided and be of a type recommended by the Fire Department.

(2) They shall be placed as required by the Fire Department.

(3) They shall be checked and rechecked at least annually by a person qualified to determine that they are in working order, or as otherwise directed by the Fire Department.

§ 13.12. Disaster Program

All hospitals shall have a written disaster plan for the reception, treatment and disposition of numbers of casualties from a single catastrophe, as required by the Joint Commission on Accreditation of Hospitals. This plan shall be in writing and shall be furnished to the Commissioner, together with the application for license. Any change in the disaster plan shall be submitted to the Commissioner prior to application for renewal of license. The plan should cover the following and provide for:

(a) General Director (and alternates) of disaster activities.

(b) Medical Director (and alternates) of disaster activities.

(c) Nursing Director (and alternates) to provide:

(1) Nursing personnel, drawn from special departments, off-duty status, or inactive lists.

(2) Personnel assignments to augment medical staff for medical functions.

(d) Medical Personnel for the following functions:

Initial care of injured.
Shock treatment.
Emergency surgery.
Burn treatment.
Anesthesia.
Minor treatments.
Treatment of toxic conditions.
Discharge of patients to provide additional beds.

(e) Transfer of personnel from one hospital to another.

(f) Location of functions listed above.

(g) Expansion of bed complement to meet such an emergency.

(h) Emergency sources of medical supplies.

(i) Collection of data on casualties received and treated.

(j) Public information and traffic control.

(k) Switchboard routine.
(l) Training and drills.
(m) Liaison with local civil defense authority.

All personnel shall be instructed as to their responsibilities and shall become thoroughly familiar with the written disaster plan of the hospital. At least twice each year a simulated situation shall be created for the purpose of training personnel and determining the adequacy of the plan.

§ 13.13. Visiting Rules and Regulations

(a) Each hospital shall adopt and enforce liberal rules consistent with the welfare of the patients governing the admission of visitors to the hospital. Separate rules may be made governing admission to nursery, pediatric, obstetrical, medical and surgical adult nursing units. Rules for visitors shall be posted in a conspicuous place.

(b) No visitor shall knowingly be admitted to a hospital who has an infectious disease, or who has recently recovered from such a disease, or who has recently been in contact with such a disease.

(c) Children shall be permitted to visit hospitalized members of their immediate family unless prohibited by the patient's physician and subject to the restrictions which are necessary to prevent the spread of communicable disease.

(d) Visitors shall neither sit nor place their clothing on beds.

§ 13.14. Reports to the Department

In addition to specific reports required by this code, the licensee shall report as follows:

(a) Annual Report. Each hospital shall submit before February 15th of each year, on forms supplied by the Department, an annual report for the preceding calendar year.

(b) Accident Reports. Whenever an accident or an unusual incident occurs in a hospital resulting in injury to a patient or other person, the responsible individual on duty shall complete an approved accident report in duplicate, the original shall be sent to the hospital administration office and the copy shall be sent to the Department within seventy-two (72) hours thereafter. Where a patient is involved an appropriate notation shall be made in the patient's record.

(c) The minutes of all Medical Board or Executive Committee meetings; of all Credentials Committee meetings; and of all Tissue Committee meetings. These minutes shall be submitted to the Commissioner within twenty-one (21) days after such meetings.

(d) All proposed changes as outlined in Section 11.06 of this code.

(e) Other reports as the Commissioner may from time to time specifically request.

ARTICLE XIV MEDICAL STAFF ORGANIZATION

Section

14.01. Medical Staff Organization.
14.02. Medical Board.
14.03. Medical Staff Appointments.
14.04. Medical Staff By-Laws and Rules and Regulations.
14.05. Committees.
14.06. Staff Meetings.
14.07. Physicians-in-Residence.
14.08. Organization of Clinical Services.

§ 14.01. Medical Staff Organization

The physicians appointed to practice in a hospital shall be organized to provide an effective means for the licensee to discharge responsibility for the scope and quality of medical care and to provide opportunity to the medical staff for the interchange of medical knowledge.

§ 14.02. Medical Board

(a) The Medical Board shall consist of a minimum of nine (9) and a maximum of thirteen (13) physicians who are currently licensed to practice medicine in the State of New York and shall include but not be limited to the following: the president of the medical staff; a qualified internist who shall be the Chief of the Medical Service; a qualified surgeon who shall be the Chief of the Surgical Service; a qualified pathologist who shall be in charge of the Laboratory Service; a qualified anesthesiologist who shall be the Chief of the Anesthesiology Service; a qualified roentgenologist who shall be the Chief of the Radiological Service; a qualified obstetrician and gynecologist who shall be the Chief of the Obstetrical and Gynecological Service, if maternity services are provided in the hospital; a qualified pediatrician, who shall be the Chief of the Pediatric Service, if children are cared for in the hospital.

(b) Except as otherwise required herein, the remainder of the Medical Board may be composed of general practitioners who are members of the medical staff.

(c) A licensee may be a member of the Medical Board if he is professionally qualified.

(d) Appointment. The members of the Medical Board, except the president of the medical staff, shall be appointed by the licensee and their appointment shall be subject to confirmation by the Commissioner. They shall be qualified in their respective specialties as set forth in this code and shall, in addition, possess such other professional qualifications as may be required by the Commissioner. Their appointment shall be for a term of one (1) year. Any proposed change in the membership of the Medical Board shall be subject to the approval of the Commissioner and shall be immediately reported to him in writing.

(e) The hospital administrator shall be an ex-officio member of the Medical Board and of its Executive Committee.

(f) The Medical Board shall meet at least once each month except during the summer months when the Executive Committee may be empowered to act on behalf of the Medical Board. Minutes of each meeting shall be retained and filed at the hospital in a minute book.

§ 14.03. Medical Staff Appointments

(a) Chiefs of Service. The licensee shall appoint a qualified specialist as Chief or Physician-in-Charge of each of the departments, divisions, services or subspecialties, to function as an officer of the hospital for the supervision of the activities of these services under the authority of the by-laws of the medical staff. The licensee may receive nominations for a Chief of Service from the Medical Board. Only the Chiefs of Medicine, Surgery, Pathology, Anesthesiology, Radiology, Obstetrics and Gynecology, and Pediatrics shall automatically be members of the Medical Board. Appointment of a Chief of Service is subject to confirmation by the Commissioner. Each Chief of Service or Physician-in-Charge, in accepting such an appointment, shall indicate in writing that he accepts the responsibilities imposed by such an appointment including an ongoing assessment of the quality of care on his service.

(b) Other appointments. Medical staff appointments shall be made by the licensee only upon approval of the Medical Board and the recommendations of a Credentials Committee.

(1) Terms of appointment. Appointments shall be for a term of one (1) year.

(2) Rejection of application. Irrespective of the recommendations of the Medical Board, an application may be rejected by the licensee if the applicant's appointment is determined to be inconsistent with the best interests of the hospital and of its patients. The licensee may defer action on an application without prejudice. Rejection of an application by the Medical Board or its Credentials Committee or by the licensee shall not violate the laws of the State relating to discrimination because of race, creed, color or legally authorized method of medical practice.

(3) Qualifications for appointment.

(a) Each appointment, and/or the granting of privileges, shall be made only upon documentation evidencing possession of a current license to practice medicine, osteopathy dentistry or podiatry in the State of New York. As amended by the Board of Hospitals Sept. 23, 1964.

(b) A recommendation of the Credentials Committee to the Medical Board.

(c) The endorsement of the appropriate Chief of Service.

(d) The applicant's signed agreement to refrain from unethical practices, including fee splitting.

(e) The applicant's signed agreement to be bound by the by-laws and rules and regulations of the medical staff now in effect or enacted in the future.

(f) Such other evidence of character, training and ability as may be required by the licensee, the by-laws of the medical staff, the Credentials Committee or the Medical Board.

(4) Privileges. Each staff appointment shall specify clearly and explicitly the nature of the clinical privileges granted together with any conditions which may attach thereto. In an emergency, temporary privileges may be set by the chief of the service involved. No physician, dentist or podiatrist shall be permitted to treat patients in a hospital until his application for staff appointment, and/or privileges, has been acted upon in accordance with the provisions of this code. As amended by the Board of Hospitals Sept. 23, 1964.

(5) Reappointments and changes in privileges. Yearly reappointment shall be based on the recommendation in writing of the appropriate chiefs of service. Changes in privileges shall be based on the recommendations in writing of the appropriate chiefs of service as approved by the Medical Board.

(6) Rank. In those hospitals where physicians are ranked, the rank of Attending and Associate Attending physician shall be assigned only to qualified specialists as defined in this code.

(7) Termination of appointment. The by-laws of the medical staff shall make provision for termination of an appointment. The licensee, on his own initiative, may at any time terminate a medical staff appointment. The licensee shall terminate a medical staff appointment upon the recommendation of the Medical Board but such termination of a medical staff appointment shall not be based upon discrimination because of race, creed, color or legally authorized method of medical practice.

§ 14.01 Medical Staff By-Laws and Rules and Regulations

(a) There shall be established, in writing, a set of by-laws and rules and regulations consistent with the provisions of this code, which shall be approved by the licensee. These by-laws and rules and regulations shall establish scientific, professional and ethical standards for the hospital. A copy of the proposed by-laws and rules and regulations or any changes therein shall be filed with the Commissioner within twenty (20) days after they have been adopted.

(b) Contents. The by-laws and rules and regulations shall include the specific requirements of this code in addition to making provisions for the following:

(1) The objective of the hospital and its medical staff;
(2) The categories and ranks if any of the medical staff and the responsibilities and prerogatives of each;
(3) The qualifications for membership;
(4) The procedure for appointment and term of appointment;
(5) The granting of privileges;
(6) The organization of the medical staff by clinical services;
(7) The manner of appointment, terms of office and duties of the Medical Board and Officers.
(8) The Committees; their purposes, duties, composition, manner and terms of appointment, frequency of meeting and method of reporting;
(9) Meetings; quorum; attendance; agenda; special meetings;
(10) Clinical reviews and controls;
(11) Standard clinical procedures;
(12) The keeping of minutes, with provision for a copy of all minutes to be sent to the licensee;
(13) The manner of adoption of amendments, with provision for the prompt presentation of amendments, and for ratification of the by-laws in their entirety at least once in every three (3) years.

(c) Consultations.

(1) Rules governing professional consultations shall be included in the by-laws or rules and regulations and shall include those conditions which require consultation as developed by each Chief of Service and as recommended by the Joint Commission on the Accreditation of Hospitals. They shall include the requirement that the findings and recommendations of the consultant be entered on the patient's record at the conclusion of the consultation and signed by the consultant.

(2) Qualifications of consultants. A consultant must be qualified to give an opinion in the specialty in which his opinion is sought. The status of consultant is to be determined by the Medical Board on the basis of the physician's training, experience and competence.

(3) Appointments of consultants. The performance of a consultation shall be limited to members of the staff who are qualified in their respective specialties and have been designated as staff consultants by the Medical Board and approved by the Commissioner. If a separate consulting staff is created, appointment thereto shall be subject to confirmation by the Commissioner. Qualified outside consultants may be called by the patient's physician at the request of the patient or his family. Such consultants must meet the approval of the appropriate chief of service or his designated representative.

(4) Requests for consultation. The patient's private physician is responsible for requesting consultation whenever medically indicated or when required by the by-laws or rules and regulations of the medical staff or when requested by the patient.

(5) Conditions requiring consultation. Except in an emergency, consultations shall be required:

(a) For first caesarian sections.

(b) For curettages or other procedure by which a known or suspected pregnancy may be interrupted.
(c) Before operations performed for the sole purpose of sterilization on both male and female patients.
(d) For cases in which, according to the judgment of the physician or the chief of the service where the patient is receiving care:
(1) The patient is not a good risk for operation or treatment.
(2) The diagnosis is obscure.
(3) There is doubt as to the best therapeutic measures to be utilized.
(e) Other conditions as recommended by the Maternity and Newborn Section of the Health Department.

(d) Research.
(1) The proper care, treatment and investigations of patients are a responsibility of the Medical Board.
(2) The Medical Board shall adopt rules and regulations for all procedures for the safe and proper care, treatment and investigation of patients and specifically for those which require informed consent of patients in writing.
(3) A member of the professional staff who desires to conduct an investigation into a medical problem involving a patient shall submit such a request to the Chief of the Service responsible for that patient.
(4) The Chief of the Service concerned must approve the request in advance
(5) Every application shall be referred to and be approved by the Research Committee of the Medical Board and by the Medical Board.

(e) Additional requirements of the by-laws and the rules and regulations:
(1) Clinical record. A clinical record of every patient shall be kept. It shall contain an admission diagnosis, history, physical findings, physician's progress notes, consultation reports, reports of results of all laboratory tests, X-Ray examinations, operations, anesthesia, treatments, examinations of tissue and a discharge note which shall include final diagnoses, condition of patient and disposition including plans for after care when indicated.
(2) All physician's orders for treatment shall be entered on an appropriate sheet of the clinical record and shall be signed by the attending physician.
(3) The nurse's records of treatment and symptoms shall be entered on an appropriate sheet of the patient's clinical record and shall be signed by the nurse.
(4) Medications. Every order for a medication and for the discontinuance of such medication shall be written in ink on a separate medication page of the patient's clinical record or in a medication order book and shall be signed by the prescribing physician. The names of drugs shall be written so as to be clearly identifiable. No medication shall be administered unless the order for it has been written, except under such circumstances as may otherwise be provided in the by-laws and rules and regulations of the medical staff. The Medical Board shall have authority to approve medications used in the hospital and shall establish rules governing orders for the use of habit forming or dangerous drugs. [see § 16.02 (f)]
(5) Doctors sign-in registers. All hospitals shall provide a system for the signing in and signing out by staff physicians. This shall be a permanent record.

§ 14.05. Committees

All standing committees shall be set forth in the by-laws and approved by the Chairman of the Medical Board. An appropriate chief of service shall be a member of and preside at each meeting of all standing committees. The standing committees to be appointed shall include but not be limited to the following:

(a) Executive Committee.
(1) The licensee shall appoint this committee from the members of the Medical Board.
(2) It shall consist of not less than five (5) chiefs of service.
(3) The administrator shall be an ex-officio member of this committee.
(4) The Executive Committee shall coordinate the activities and general policies of the various departments and services; act for the medical staff under such limitations as may be imposed on the Medical Board by the licensee; receive and act upon requests of other committees of the Medical Board; receive reports and communications from chiefs of services, other committees, the administrator and the licensee, and take appropriate action and formulate such recommendations for adoption by these groups as seem required.

The Executive Committee or the Medical Board shall meet at least once each month and maintain a permanent record of its proceedings and actions. The minutes of the meet-

ings of the Medical Board or the Executive Committee shall be forwarded to the Commissioner within twenty-one (21) days after each meeting.

(b) Credentials Committee. The Credentials Committee shall consist of not less than three (3) and not more than five (5) chiefs of service. It shall make recommendations to the Medical Board in respect to appointments, reappointments and limitations of privileges for all active and courtesy staff members. This committee shall investigate the credentials of physicians seeking appointment to the staff of the hospital. The committee shall submit its reports and recommendations in writing to the Executive Committee or to the Medical Board which, in turn, shall make appropriate recommendations for the final decision of the licensee.

(c) Medical Records Committee. It shall review the clinical records of the hospital at least once each month and require that these records conform to the standards established by the Medical Board, the by-laws and the rules and regulations of the medical staff and by the Joint Commission on Accreditation of Hospitals.

(d) Medical Audit and Utilization Committee. It shall perform medical audits of the work of the professional staff at least once each month and shall keep a record of its audits. This audit shall include a review of:

(1) All deaths which occur in the hospital.
(2) Hospital admissions.
(3) Hospital discharges.
(4) Wound and cross infections.
(5) The ordering of required consultations and the failure to order required consultations.
(6) The adequacy and medical indication for laboratory and X-ray examinations.
(7) Unnecessary in-patient or ambulatory diagnostic and treatment procedures.
(8) Length of patient stays.

(e) Tissue Committee. This committee shall consist of not less than five (5) physicians representing amongst others the specialties of medicine, surgery, obstetrics and gynecology, and pediatrics and shall include the hospital pathologist. This committee shall meet at least once each month and shall review all operative cases and report, in writing, to the Medical Board concerning the agreement or disagreement between preoperative diagnosis, postoperative and pathological diagnosis and the acceptability of the surgical procedure undertaken. It shall review the pathologist's reports on the tissues removed at operations and the justification for surgery.

(f) Joint Conference Committee. The administrator shall be an ex-officio member of this committee. It shall function as the official means of liaison between the medical staff, the licensee and the administrator. It shall advise the licensee on all matters of joint concern, on all reports and recommendations of the Medical Board, and on all policy decisions contemplated by the licensee.

(g) Pharmacy and Therapeutics Committee. The hospital pharmacist shall act as secretary of this committee. This committee shall review the operation of the Pharmacy and may prepare or adopt a formulary for the hospital. It shall pass on the use of all drugs approved for clinical trial by the Food and Drug Administration and shall assure that all Federal, State and local laws and regulations are observed.

(h) Infection Control Committee. The committee shall include the Pathologist and at least a member of the nursing and housekeeping staffs. It shall develop a written policy for the reporting of infections. It shall be responsible for the investigation, control and prevention of infections within the hospital and shall keep a record of its findings and recommendations.

(i) Therapeutic Abortion and Sterilization Committee. This committee shall include the chief of the Department of Obstetrics and Gynecology and at least one (1) psychiatrist. The committee may call upon members of the various specialties to aid in its deliberations. It shall pass judgement on the particular case and recommend to the physician his course of action.

(j) Other committees. At the discretion of the Medical Board, or the Commissioner, the hospital shall establish such other committees as from time to time may be desired or needed. The responsibilities of such committees shall be clearly defined and recorded in the minutes of the Medical Board.

(k) Committee procedures. Summaries of the reports of each committee, including evaluations and recommendations, shall be made a matter of written record and reported regularly to the Medical Board.

§ 14.06. Staff Meetings

The requirements of the Joint Commission on Accreditation of Hospitals shall be the basis of required meetings of the medical staff. These meetings shall be required to review the clinical work of the staff of the hospital.

(a) The number and frequency of medical staff meetings shall be determined by the Medical Board and clearly stated in the by-laws of the medical staff.

(b) Attendance requirements for all medical staff members shall be determined by the Medical Board. The requirements for each individual member of the staff and for total attendance at each meeting shall be clearly stated in the by-laws of the medical staff. Records of attendance shall be kept.

(c) Monthly departmental conferences shall be held in those hospitals where the clinical services are well organized and where each service is large enough to meet as a unit.

(d) Clinical pathological conferences may be substituted for a departmental conference, provided an adequate review of the clinical work is covered by one or another of such conferences.

(e) Complete written minutes shall be kept of all staff meetings.

(f) The agenda of any regular meeting as recommended by the Joint Commission on Accreditation of Hospitals shall be:

(1) Business.
- (a) Call to order.
- (b) Approval of the minutes of the last regular meeting and of all special meetings since the last regular meeting.
- (c) Unfinished business.
- (d) Communications.
- (e) Reports of standing and of special business committees.
- (f) New business.

(2) Medical.
- (g) Review and analysis of the clinical work of the hospital.
- (h) Reports of standing and of special medical committees.
- (i) Discussion and recommendations for improvement of the professional work of the hospital.
- (j) Adjournment.

(g) The agenda at special meetings shall be:
- (1) Reading of the notice calling the meeting.
- (2) Transaction of the business for which the meeting was called.
- (3) Adjournment.

§ 14.07. Physicians-in-Residence

(a) Physicians-in-residence (house officers) currently licensed to practice medicine in the State of New York shall be in attendance in the hospital at all times. Such physicians shall devote their time in the hospital exclusively to hospital duties and shall not engage in the private practice of medicine during active scheduled tours of duty.

(b) There shall be in attendance at all times at least one (1) physician-in-residence for each one hundred (100) beds.

§ 14.08. Organization of Clinical Services

(a) Organization. It shall be the responsibility of the licensee to see that the medical staff is organized into appropriate clinical services to reflect the types of patients admitted to the hospital. The by-laws and rules and regulations of the medical staff shall provide for the organization of the staff into specialty services. Each physician appointed to the staff in any capacity shall serve one (1) or more of the departments, divisions, services or specialty staffs. A hospital shall develop such services and subservices as the Medical Board or the Executive Committee of the Medical Board may recommend. When a required service or an elective service or a subservice is maintained, the licensee and the Medical Board or the Executive Committee shall be responsible for its operation in accordance with the by-laws of the medical staff and the provisions of this code.

(b) Chiefs of service or physicians-in-charge.

(1) Chiefs of service or physicians-in-charge shall be qualified specialists.

(2) Responsibilities. A chief of service or physician-in-charge shall have at least the following responsibilities:
- (a) To advise the licensee on the problems and activities of his service.
- (b) To supervise the clinical work of his service and participate in conference and consultation activities.
- (c) To advise the medical staff on by-laws, clinical procedures, work of members and qualifications of applicants.
- (d) To supervise the house staff or physicians-in-residence or others assigned for care of patients.
- (e) To conduct educational activities.
- (f) To serve as a member of the Medical Board and/or Medical Board Executive Committee.
- (g) To prepare required periodic reports.

(c) Clinical services which shall be maintained.
(1) A Department of Medicine.
(2) A Department of Surgery.
(3) A Department of Anesthesia.
(4) A Department of Laboratories.
(5) A Department of Diagnostic Radiology.

NOTE: Services which may be maintained:
(1) Dentistry. Such service, if provided, shall conform to the requirements of this code (see § 15.06).
(2) General Practice. Such service, if provided, shall conform to the requirements of this code (see § 15.05).
(3) Maternity and Newborn. Such service, if provided, shall conform to the requirements of this code and the New York City Health Code.
(4) Optometry. The licensee may make arrangements to provide optometry services at the request of the patients' physician. Such service, if provided, shall be supervised by a qualified ophthalmologist.
(5) Pediatrics. Such service, if provided, shall conform to the requirements of this code (see § 15.09).
(6) Physical Medicine and Rehabilitation. Such service, if provided, shall conform to the requirements of this code (see § 15.11).
(7) Podiatry. The licensee may make arrangements to provide a podiatry section, within the Department of Surgery. Such service, if provided, shall conform to the requirements of this code (see § 15.15).

ARTICLE XV PROCEDURES, RULES AND REGULATIONS GOVERNING CLINICAL AND LABORATORY SERVICES

Section
15.01. Medical Service or Department.
15.02. Surgical Service or Department.
15.03. Anesthesia and Inhalation Therapy Department.
15.04. Inhalation Therapy.
15.05. General Practice Department.
15.06. Dental Service or Department.
15.07. Maternity Service or Department.
15.08. Newborn Service or Department.
15.09. Pediatrics Service or Department.
15.10. Electrocardiography.
15.11. Physical Medicine and Rehabilitation Service or Department.
15.12. Radiology Service or Department.
15.13. Pathology and Clinical Laboratory Service or Department.
15.14. Blood Bank.
15.15. Podiatry Service or Department.

§ 15.01. Medical Service or Department

(a) Organization. The organization of the Medical Service or Department and all subservices or sections shall conform to the requirements of this code.

(b) Coverage. The Medical Services shall have qualified internists and other qualified specialists in the appropriate subspecialties of medicine available at all times for consultation and emergency care. A schedule of "on service" or "on call" assignments shall be prepared for this purpose, posted and mailed to all members of the Medical Service or Department.

§ 15.02. Surgical Service or Department

(a) Organization. The organization of the Surgical Service or Department and all subservices or sections shall conform with the requirements of this code.

(b) Membership. The surgical staff shall consist of qualified surgeons with appropriate surgical privileges as specified in the by-laws or rules and regulations of the medical staff.

(c) Privileges. Privileges for each member of the surgical and gynecological departments shall be specified in writing by the corresponding chief of service, approved by the Medical Board and inscribed in the records of the hospital and in the files of the operating room supervisor. These statements of operative privileges shall clearly indicate the type and extent of surgical procedures which each surgeon is authorized to perform, provided however, that major and/or complicated surgery shall be performed only by qualified specialists as defined in this code.

(d) Special elective surgical procedures. The performance of elective surgical procedures which require special equipment and laboratory services, such as open heart surgery, neurosurgery, middle ear surgery, shall be performed in a hospital which is

specifically equipped and staffed with experienced personnel for this purpose and which has a completely staffed and equipped recovery room. A hospital contemplating these types of elective surgical procedures shall first apply to the Commissioner for approval before performing any such procedures. In evaluating such requests, the Commissioner may use standards which have been promulgated by recognized standard setting agencies and institutions.

(e) Coverage. The surgical service shall have qualified surgeons and other qualified specialists in the appropriate subspecialties of surgery available at all times for consultation and emergency treatment. A schedule of "on service" or "on call" assignments shall be prepared for this purpose, posted and mailed to all members of the service. If a patient's condition requires consultation and/or emergency treatment which requires special facilities and equipment which cannot be given by the staff of a hospital, provision shall be made either for outside consultation or transfer to a hospital where such a condition can be treated.

(f) Surgical assistants. In major surgery, the surgeon shall have a capable physician assistant who is competant and ready to continue the operation at any moment in case of necessity.

(g) Nursing. A registered professional nurse shall be on duty in each operating room where an operative procedure is being performed. Members of the operating room nursing staff who are qualified to assist at emergency operations shall be promptly available.

(h) Critical equipment. A list of standard, movable emergency equipment specified by the surgical staff shall be prepared and posted in the department. This required equipment shall be provided by the licensee and shall be available at all times in the surgical suite.

(i) Critical medications and solutions. The surgical staff shall specify and the licensee shall provide the emergency drugs which shall be available at all times in the surgical suite.

(j) Pre-operative procedures. The following procedures or conditions set forth in the medical staff by-laws or rules and regulations shall be fulfilled, except in emergencies as herein provided, before a patient requiring general or regional anesthesia or analgesia undergoes surgery:

(1) A systematic physical examination performed by the attending physician with results recorded in the patient's chart. If the examination is performed by a physician-in-residence, then the attending physician shall review the finding and write a note in the patient's chart. Physicians-in-residence need not perform physical examinations on maternity and gynecology admissions.

(2) A medical history, if obtainable, taken by the attending physician and recorded in the patient's chart. This history shall include but not be limited to anesthetic drug sensitivity, recent food intake, and other appropriate findings.

(3) Laboratory examinations. Urinalysis including but not limited to: gross appearance, specific gravity, glucose, albumin, ph and microscopic findings. Blood examination including but not limited to: hemoglobin, red blood cell count, white blood count and differential, blood group and type.

(4) Consultations as indicated and as required by the by-laws and the rules and regulations.

(5) The provisional diagnosis shall be established and entered in the chart by the attending surgeon.

(6) Appropriate consents for surgery shall be obtained and incorporated in the patient's chart. In emergencies, performance of surgical procedures without consent shall be performed as governed by law.

(7) Authority of the surgeon to undertake the proposed operation, under assigned privileges, shall be clear and unequivocal.

(8) A standard control mechanism shall be adopted by the hospital for verification of the patient's identity and for verification of site and side of body to be operated upon; this procedure shall be scrupulously performed before any surgical procedure is begun.

(9) Such other requirements as may be adopted by the medical staff shall be followed.

(10) Exceptions. A surgeon may make exceptions to any of the above preoperative procedures only if, in his judgement, the risk of delay is greater than the risk of proceeding and this determination is recorded in the chart subject to review by the appropriate committee of the Medical Board and reported in the minutes of the Medical Board.

(k) Examination of tissue. All surgical specimens, amputated parts and other tissues removed from a patient in an operation shall be examined by a qualified pathologist and all microscopic sections of such tissues shall be retained in the custody of the pathologist. The pathologist shall be responsible for the gross and microscopic examination of all tissues, exudates, transudates, surgical specimens and amputated parts. He shall be responsible for the preparation of all laboratory reports which shall bear his signature and shall be included in the patients' charts; copies of these reports shall be filed in the laboratory. Amputated parts of living persons shall be disposed of in accordance with the requirements of the New York City Health Code and as directed by the patient or other authorized person.

(l) Foreign objects. The surgical staff shall establish and enforce routine controls to ensure that foreign objects such as instruments, linens, sponges, etc., are not left in body cavities following surgery.

(m) Operating Room policies, rules and regulations.

(1) Restrictions. Admission to the operating room or suite and recovery area shall exclude all persons not required to be there. No person shall be permitted to enter the area with known communicable, respiratory, skin, gastrointestinal or other communicable disease, except with medical approval. Notice of such restrictions shall be clearly posted at the entrance to the suite.

(2) Reporting personal illness. The hospital shall require that any person employed in the surgical operating suite report immediately to his supervisor any signs or symptoms of illness. The Chief of Surgery or other designated physician shall be notified.

(3) Clothing and footwear.

(a) Rules governing satisfactory clothing and footwear for entry beyond the dressing rooms shall be adopted and clearly posted at the entrance to the suite. Such rules shall require the change of outer clothing and footwear upon each entry or re-entry, and shall conform to the requirements of the National Fire Protection Association for protection against anesthetic explosion.

(b) Persons in anesthetizing locations shall not wear silk, wool or synthetics, except unmodified rayon, as slips or outer garments.

(c) All persons entering anesthetizing locations shall wear conductive footwear or other floor contacting devices which shall have been tested on the wearer and found to be satisfactorily conductive.

(4) Conductivity testing.

(a) Floors and equipment shall be tested with an ohmmeter at least monthly, with results recorded.

(b) Persons entering anesthetizing locations shall determine at least once daily, by means of the testing apparatus provided, that they are in electrical contact with the conductive floor.

(5) Aseptic techniques. Standard aseptic techniques shall be adopted and followed and all personnel shall be trained therein.

(6) Face masks shall be used, with the mask covering both nose and mouth, by all personnel in the operating rooms throughout all surgical procedures.

(7) Patients shall be screened for infectious disease in advance of all surgical procedures. If it is necessary for the procedures to be carried out, all possible precautions against spread of infection are to be taken.

(8) Clean-up procedures shall be established for the cleansing of operating rooms after each surgical procedure and at the close of the day. Such procedures shall be posted on the operating suite bulletin board or placed in the operating room manual. Where indicated these procedures shall include but not be limited to:

(a) Removal and disposal of dry and liquid wastes;

(b) The cleansing of floors, walls and fixtures;

(c) The cleansing of furniture and equipment;

(d) The removal and handling of linen, drapes and garments, masks and gloves;

(e) The sterilization of special equipment such as endoscopy instruments, stethoscopes, cautery needles, etc.

(9) Use of Operating Rooms for emergencies. The operating rooms shall not be used for the initial examination of emergency patients. Except in dire emergencies, out-patients shall be cleaned and gowned or draped before entering an operating room or suite.

(10) Scheduling of cases. As a general rule it is desirable that the sequence of cases on the daily schedule shall proceed from clean to contaminated. One

(1) operating room should be used for contaminated cases and shall be cleaned between operations.

(11) Register of operations. A bound book shall be maintained in the operating suite containing the following information with respect to each and every surgical procedure carried out in the operating rooms:

(a) The date of operation;
(b) The name of patient;
(c) The age of patient;
(d) The sex of patient;
(e) The room number of patient;
(f) The hospital number of patient;
(g) The service;
(h) The number of the operating room;
(i) The pre-operative diagnosis appearing on chart;
(j) The post-operative diagnosis;
(k) The surgical procedure(s) performed;
(l) The time operation started and completed;
(m) The surgeon;
(n) The assistant surgeon;
(o) The other assistants;
(p) The anesthetist(s);
(q) The anesthetic agents used;
(r) The name and title of the scrub nurse;
(s) The name and title of the circulating nurse;
(t) The sponge count and the name of the nurse who did it;
(u) The disposition of patient following completion of surgery.

(12) Smoking. Smoking shall be prohibited except in those areas designated by the Fire Department.

(13) Grounding patient. Electrical connection of the patient to the conductive floor shall be assured by a conductive strap in contact with the patient's skin, with one (1) end of the strap fastened to the metal frame of the operating-table, or by equivalent means.

(14) Blankets. Woolen blankets shall not be permitted in anesthetizing locations

(15) Anesthesia machines. Anesthesia machines shall remain uncovered in order to avoid the possible accumulation of combustible gases.

(16) Cautery. If cautery is to be employed, flammable germicides shall not be applied to the patient, nor shall a combustible anesthetic be employed unless the surgeon specifies that the accompanying risk must be taken for the patient's benefit.

(17) Floor cleaning materials. Floor cleaners or dressing which adversely affect the electrical conductivity of the flooring shall not be used.

(n) Surgical reports. An accurate and complete description of the findings and techniques of all operations shall be made on the patient's clinical record or dictated immediately following surgery. Each report of an operation shall be signed by the surgeon and shall include the names of the surgeon's assistants, types of anesthesia and the names of the anesthetists, preoperative diagnosis, postoperative diagnosis and result.

NOTE: The Joint Commission on Accreditation of Hospitals defines major surgery as any procedure in which there is considered to be a hazard to life or any procedure in which a major body cavity is opened.

§ 13.03. Anesthesia and Inhalation Therapy Department

(a) Organization. The organization of the Department of Anesthesia and Inhalation Therapy shall be comparable to that of other services or departments and shall conform with the requirements of this code. In addition to the foregoing, there shall be required for every patient a pre-anesthetic evaluation with findings recorded by an anesthesiologist within twenty-four (24) hours before surgery; and a post-anesthetic follow-up with findings recorded by an anesthesiologist or a registered nurse-anesthetist as indicated below.

(b) Anesthesia staff.

(1) If one (1) or more physician anesthesiologists furnish anesthesia services, a chief or physician-in-charge shall be appointed by the licensee.

(2) Except in immediate emergencies, general anesthesia shall be administered only by qualified anesthesiologists and registered nurse anesthetists.

(3) Regional anesthesia can be administered by qualified anesthesiologists, and members of the surgical and gynecological staff.

(4) Anesthesia personnel shall be available at all times in sufficient numbers to meet emergency needs. A schedule of assignments for such purposes shall be prepared, posted and sent to all members of the anesthesia department.

(c) Supervision.

(1) Registered nurse anesthetists shall administer anesthesia or analgesia only under the supervision of a qualified anesthesiologist.

(2) One (1) person shall not administer anesthesia to two (2) patients in separate rooms at the same time.

(d) Control. The licensee shall not transfer his ultimate responsibility for the operation of the Anesthesia Department, the protection of the patients or compliance with this code. However, the technical conduct of the Department shall be the responsibility of the chief anesthesiologist.

(e) Critical equipment. The Chief or physician-in-charge shall prepare a list of life-saving equipment which shall be provided by the licensee and shall be kept in readiness at all times. This list shall be approved by the Medical Board.

(f) Anesthetic agents.

(1) All anesthetic agents employed in the hospital shall be approved by the physician-in-charge.

(2) The storage of flammable anesthetic gases shall be only in an approved location. Storage of these anesthetic gases within an anesthetizing location shall be prohibited except for those cylinders connected to anesthetic apparatus.

(g) Post-anesthetic supervision. Patients under, or recovering from, anesthesia shall remain under continuous, direct nursing supervision until vital signs have become stabilized. Any nurse performing this duty shall have been instructed in the management of post-anesthetic patients, shall have no other duties during the time she is supervising such patients and shall have available the services of a surgeon or anesthesiologist in the hospital.

(h) Clinical records.

(1) Standard anesthesia record forms shall be established. They shall cover the pre-operative, operative and post-operative phases of anesthesia management.

(2) They shall be completed and signed by the person administering the anesthesia.

(3) They shall contian but not be limited to the following information:

(a) Type and amount of pre-operative medication.

(b) Time of administration of the pre-operative medication.

(c) Anesthetic agents used and quantities.

(d) Medications, solutions or blood transfusions given; time started and time ended.

(e) Reaction of patient.

(f) Notes on the patient's condition.

(g) Chart of patient's pulse, blood pressure and respiration.

§ 15.04. Inhalation Therapy

(a) A qualified physician, preferably a qualified anesthesiologist, shall be appointed to supervise inhalation therapy, including training of technicians, selection and maintenance of equipment, standards of operation of this service and other matters pertaining thereto.

(b) There shall be at least one (1) trained oxygen therapy technician on duty or on call in the hospital at all times.

(c) Training of technicians. Both full and part-time oxygen therapy technicians including orderlies and others regularly providing service, shall receive a course of training approved by the physician-in-charge.

(d) Oxygen and rela[redacted] therapy shall be given only on the written and signed order of a physician except that in an emergency, telephone orders may be accepted and acted upon. The physician shall confirm such orders in writing within twenty-four (24) hours.

(e) Oxygen flow and measurement of concentration.

(1) Devices. The hospital shall have in working order one (1) or more oxygen concentration measuring devices for the newborn service and one (1) or more for the medical-surgical services.

2) Form of prescription. All orders for oxygen by tent, incubator or other such enclosure should be expressed in terms of desired concentration rather than rate of flow. A procedure shall be established involving the periodic determination of oxygen concentrations and the recording thereof in the patient's medical record.

3) Premature infants. Concentration controls are mandatory in the case of premature infants.

4) Oxygen safety measures. Policies and procedures, as well as appropriate facilities, shall be provided for the safe storage, distribution and administration of oxygen. These shall be based upon the current standard for non-

flammable medical gas systems as recommended by the National Fire Protection Association and the requirements of the Fire Department for design, construction and erection of central oxygen piping systems.

(f) Resuscitation. Equipment for resuscitation of patients shall be provided and personnel trained in its use shall be available. There shall be an established written procedure for the periodic, signed check of condition and working order of this equipment.

§ 15.05. General Practice Department

If a hospital organizes a Department of General Practice as a segment of the medical staff comparable to that of other departments, the following regulations shall apply:

(a) Responsibilities of this department shall be administrative and educational only.

(b) The Department of General Practice is not a clinical service and no patients are to be admitted to this department. The members of the Department of General Practice shall, on recommendation of the Credentials Committee, have privileges on the clinical services of other departments in accordance with their training and experience. On any service in which any general practitioner shall have privileges, he shall be subject to the rules of that service and subject to the jurisdiction of its chief.

§ 15.06. Dental Service or Department

(a) Dental staff. Dentists shall be eligible for membership in the surgical department and shall be subject to the regulations thereof.

(b) Dentist-in-charge. If dental patients are accepted, a chief or dentist-in-charge shall be appointed with the same functions as a physician-in-charge. This dentist shall function as an officer of the surgical service.

(c) Medical supervision. A patient admitted for dental care shall be under the care of a staff physician for medical supervision.

(d) Applicability of general requirements to dental patients. The requirements of this code regarding patients, particularly the requirements on admission examinations, standard general clinical procedures, pre-operative procedures, anesthesia and medical records, shall be applicable to dental patients as well.

§ 15.07. Maternity Service or Department

(a) Organization. If the hospital admits maternity patients, the licensee shall establish a clinical service in accordance with the requirements of this code. This service shall also be subject to the requirements of the New York City Health Code.

(b) Obstetrical staff. Physicians performing obstetrics shall be classified as follows:

(1) Physicians permitted to perform all types of obstetric procedures and deliveries. This group shall be limited to qualified obstetricians.

(2) Physicians permitted to perform deliveries of a normal, uncomplicated nature.

A list of the physicians and their classifications shall be available in the Administrator's office and in the office of the supervising nurse of the service and shall be filed with the Maternity and Newborn Division of the New York City Department of Health.

(c) The pertinent provisions of Sections 15.02 and 15.03 herein shall apply to this service or department.

(d) Closed units. The labor-delivery and nursery units shall be considered closed units, similar to the surgical suite and recovery room, and appropriate restrictions shall be established and posted governing entry into any such unit, in accordance with the provisions of this code. Suitable conditions may be established to permit visiting by the patient's husband in the labor-delivery unit and in the observation area of the nursing unit.

(e) Admission of patients:

(1) Screening. Each patient shall be admitted initially to a room outside the labor-delivery unit, for screening against infection and change into hospital gown, unless delivery appears imminent.

(2) Isolation. Isolation provisions outside the labor-delivery area shall be established for patients with confirmed or suspected infection. Such patients shall be delivered in an operating room if the use of a delivery room limits the ability of the hospital to care for other women in labor. Cases of infection shall be reported as required by the New York City Health Code and also to the Medical Board or appropriate subcommittee with responsibility to investigate all infections and recommended methods of control.

(3) Delivery before admission. A patient delivered before admission to the labor-delivery unit shall be isolated for a period as required or recommended by the Health Department. An infant born elsewhere than in the hospital shall be promptly placed in an observation nursery for a period of at least seven (7) days while in the hospital and shall not be admitted to the clean nursery.

(4) Blood type. Wherever possible, the blood type and RH determination shall have been made prior to admission and shall have been recorded in the patient's

chart. If for any reason this has not been done, this determination shall be made as soon after admission as practicable. At least two (2) pints of "O" negative blood shall at all times be immediately available on the labor-delivery unit.

(f) Anesthesia and analgesia when supplied to obstetrical patients shall comply with the requirements of Section 15.03 herein.

(g) Delaying of birth. The use of anesthetics, pressure on the fetal head or other physical restraints, or other methods, to inhibit the birth pending arrival of a physician is prohibited.

(h) Induction of labor. When a physician orders the induction of labor or the stimulation of labor by means of parenteral or intravenous oxytoxics, this physician or his specifically designated and qualified assistant shall be present in the hospital.

(i) Availability of physicians. An "on-call" schedule or other system shall be established to assure that a qualified obstetrician is readily available at all times to perform deliveries in the hospital.

(j) Obstetrical consultations. Physicians permitted to perform deliveries of a normal, uncomplicated nature shall be required to hold consultations with a qualified obstetrician under the conditions listed below. They shall transfer responsibility to a qualified obstetrician for those procedures which are not encompassed in their privileges as defined in Section 15.02 of this code.

(1) Every patient in active labor within the hospital for a period of twelve (12) hours or with membranes ruptured for twelve (12) hours.
(2) Use of parenteral oxytocics for induction or potentiation of labor.
(3) Every case of multiple pregnancy.
(4) Every case of abnormal presentation including breech presentation or decomposition of the breech or breech extraction.
(5) Every case of toxemia.
(6) Every case of hemorrhage; also manual removal of the placenta and packing of the uterus.
(7) Prior to all vaginal operations, with the exception of episiotomy or outlet forceps.
(8) Prior to all cesarean sections.
(9) Prior to all destructive operations.
(10) Every pregnant or puerperal patient with major medical, surgical or obstetric complications.
(11) Every patient with intrapartum fever (100.4 F. or more).

(k) Cesarean section.

(1) Privilege. A cesarean section shall be performed only by members of the staff who are in the Maternity, Gynecology or Surgery Departments and who have been granted the privilege of performing cesarean sections in accordance with Section 15.07 of this code.

(2) Operating room. A cesarean section shall be performed only in an operating room or a delivery room which meets all the requirements for an approved operating room.

(a) In addition, there shall be present in such operating or delivery room an approved incubator.

(b) Compatible blood shall be readily available for transfusion.

(k) Patient teaching.

(1) Program. The hospital, with the advice of the Maternity staff, shall formulate a program of instruction for obstetrical patients in the fundamentals of normal infant care.

(2) Provision for the individual patient. Each obstetrical patient shall receive instruction in the fundamentals of normal infant care and mother's postpartum care, whether in an antepartum course or clinic in the hospital or from her physician directly.

(l) Birth register. The obstetrical supervisor shall be responsible for maintaining a register of births, in which shall be recorded at least the name and address of each maternity patient admitted; date and time of admission; date and time of birth; type of delivery; operative procedures; physician, assistant, anesthetist; sex and condition of infant at birth. Regulations for the registration of births and stillbirths shall be in accordance with the New York City Health Code.

§ 15.08. Newborn Service or Department

(a) Organization of service. If the hospital maintains a maternity service or department, a newborn service shall also be established. The service shall be organized in accordance with the requirements of the New York City Health Code.

(b) Rooming-in of a newborn with mother is permissible.
(c) Use of incubators.
(1) Number. Newborn infant incubators for delivery room and nursery use shall be provided as required and/or ordered by the medical staff.
(2) Minimum specifications. An incubator shall meet the following criteria:
(a) Approval by Underwriters' Laboratories as fire-safe in the presence of elevated oxygen concentrations;
(b) Maintenance of temperature in incubator within a range of three (3) degrees;
(c) Capacity to maintain high humidity.
(d) Oxygen supply and controls.
(1) Oxygen supply. Each nursery shall be provided with an immediately available supply of oxygen.
(2) Controls on administration of oxygen. The routine administration of oxygen to newborn infants is prohibited. Oxygen shall be administered only on physicians' orders and the concentration of oxygen shall be restricted to levels below forty (40) per cent, except where the physician incorporates in his written order a note on the reason for prescribing a greater concentration and specifies the concentration desired.
(3) Oxygen concentration gauge. Each nursery shall be provided with an oxygen concentration gauge, which shall be tested on an atmosphere (twenty and nine tenths (20.9) per cent oxygen) prior to its use in connection with each new patient.
(4) Nurses' notes. The nursing staff shall determine the concentration of oxygen being administered to an infant at intervals of not more than four (4) hours and shall enter each determination on the infant's chart.
(e) Infections in newborns.
(1) Precautions are to be observed for control of diarrhea of the newborn, and other infections, including requirements pertaining to nursery facilities and personnel, formula preparation, visiting, reporting of diagnosed or suspected infection, nursing techniques and practices, formulation of policies, and related matters, as required by the New York City Health Code, and for prevention of Ophthalmia Neonatorum, as regulated by the New York State Sanitary Code.
(2) Marking diapers. Restrictions on marking diapers and linens with toxic substances are to be observed as required by the New York State Sanitary Code.

(f) Premature infants shall be cared for in accordance with the provisions of the New York City Health Code. A hospital which does not maintain an approved premature nursing center shall transfer all premature infants weighing two and two tenths (2.2) pounds or less to an approved premature nursery center unless, one (1) of the parents of the infant refuses in writing to permit such transfer.

§ 15.09. Pediatrics Service or Department

(a) Organization. If children under thirteen (13) years of age are admitted to a hospital, the licensee shall establish a clinical pediatric service in accordance with the provisions of this code.

(b) Size of the service shall be subject to the approval of the Commissioner and shall consist of bassinets for infants less than eighteen (18) months of age and cribs or junior beds for children over the age of eighteen (18) months.

(c) Visiting provisions. The hospital shall maintain rules which encourage the visiting of such children by their parents. Privileges shall include at least daily visiting by adults and visiting before and after surgery. Visiting rules shall be subject to modification by order of the respective attending physician.

(d) Rooming in of a mother with a child shall be permissible subject to suitable control.

§ 15.10. Electrocardiography

(a) A hospital shall maintan an electrocardiography service

(b) A qualified internist shall supervise this function and shall interpret all electrocardiograms made in the hospital.

§ 15.11. Physical Medicine and Rehabilitation Service or Department

(a) Organization. A hospital may elect to maintain facilities for physical medicine and rehabilitation. If so, the licensee shall establish the service or department in accordance with the provisions of this code.

(b) Physician-in-charge. A qualified Physiatrist or a qualified Orthopedist shall be designated as physician-in-charge of this service. If a staff physiatrist is not available, a consultant who is a qualified physiatrist shall be appointed to guide the staff.

(c) Physical Therapist. The hospital shall provide one (1) or more licensed physical therapists on a full-time or part-time basis to meet the needs of the patients for physical therapy. All physicial therapists shall serve under the supervision of the head of the department. Physical therapists shall receive and treat patients only upon referral by a physician and upon receipt of a written prescription for specific treatment. Such prescriptions shall be reviewed every two (2) weeks.

(d) Facilities. The modalities to be offered by the Physical Therapy Department shall be determined by consultation among the administration, medical staff, the physician-in-charge and the physiatrist. There shall be provided as a minimum, facilities for physicial modalities and exercise therapy.

§ 15.12. Radiology Service or Department

(a) A hospital shall maintain and operate a Department of Radiology in accodance with the provisions of the New York City Health Code.

(b) Organization. The licensee shall appoint a qualified radiologist as chief or physician-in-charge, and shall establish a department in aecordance with the provisions of this code. All physician members of this service shall be qualified radiologists.

(c) Responsibilities. The chief shall direct the service or department and shall be responsible for the seleetion, evaluation, training and supervision of the technical personnel employed in the department. He shall be responsible for the control of equipment, the making of reports and other related matters.

(d) Equipment and personnel. The hospital shall have available at all times equipment and personnel required to make satisfactory radiographs of all parts of the body and to perform proper fluoroscopy. There shall be one (1) or more qualified radiologists to make radiographic interpretations. A shockproof, mobil bedside radiographic unit shall also be provided. The space and fixed equipment requirements shall be not less than those set forth in this code.

(e) Radiotherapy. Activities of the service or department may extend to radiotherapy or radiotherapy may be a separate service or department. In the latter case, the chief or the physician-in-charge and all staff physicians in the department shall be qualified radiotherapists.

(f) Control. The licensee shall not transfer the ultimate responsibility for the operation of the Radiology Department, the protection of the patients or compliance with this code. However, the technical conduct of the department shall be the responsibility of the chief radiologist.

(g) Personnel, X-ray technicians shall have completed a high school education and shall have had one (1) year of full time paid experience as an X-ray technician in an approved hospital or in the office of a qualified radiologist or a satisfactory equivalent thereof. Effective July 1, 1965, an X-ray technician shall be held to mean a person who holds a current license issued by the Department of Education of the State of New York to practice as an X-ray technician and who has registered with such department, in accordance with the provisions of the Education Law.

(h) Patient identification. Every radiograph shall be the property of the hospital and shall bear the following information:

(1) Date of exposure.
(2) Name of hospital.
(3) Patient name, or a reliable cross-index number.

(i) Reports. A copy of each radiologic report and a complete record of any radiotherapy treatment shall be incorporated in the patient's medical record. All radiologic reports shall be signed by a qualified radiologist. A record of all reports, consultations and treatments shall be maintained in the Radiology Department.

(j) Cellulose-acetate film. Use and storage of X-ray film shall be governed by the regulations of the New York State Sanitary Code.

(k) Radio-Isotopes.

(1) Licensure. A license issued by the New York City Department of Health shall be necessary and shall determine the utilization of radio-isotope materials in the hospital for diagnosis, therapy, teaching or research.

(2) Radio-Isotope committee. The licensee shall establish a Radio-Isotope committee which shall be composed of at least the following: a qualified radiologist, a qualified pathologist, a qualified internist, a qualified hematologist, and an approved radiation physicist. The committee shall have authority over all uses of radio-isotope materials, including special conditions as may be necessary for personnel and equipment, and shall determine the procedures which shall be followed.

(3) Radiation protection officer. If radio-isotopes are utilized, one (1) member of the Radio-Isotopes Committee shall be designated as Radiation Protection Officer. He shall be charged with the responsibility for carrying out provisions for protection and for maintaining proper records and controls.

§ 15.13. Pathology and Clinical Laboratory Service or Department

(a) A hospital shall maintain and operate a pathology and clinical laboratory service or department which shall be conducted in accordance with the provisions of the New York City Health Code.

(b) When approved by the Commissioner, two or more hospitals may elect to maintain and operate a central laboratory. Such a laboratory shall:

(1) Be under the supervision of a full time director of laboratories who shall be a diplomate of the American Board of Pathology for tissue and clinical pathology.

(2) Employ a full time clinical chemist who is a diplomate of the American Board of Clinical Chemists, and a full time microbiologist who is a diplomate of the American Board of Microbiologists.

(3) Be maintained solely for the purpose of serving the member hospitals and their staff physicians and accept specimens only from the member hospitals and the physicians on their staff.

(4) Provide necessary laboratory services required in the current clinical practice of medicine. In addition, the laboratory shall provide such routine and emergency services to be performed on the hospital premises as may be deemed essential to maintain a high standard in the practice of medicine.

(5) Have a valid clinical laboratory permit issued by the Department of Health.

(c) Supervision and direction.

(1) The clinical laboratory service or department shall be under the supervision of a qualified pathologist who is certified in anatomical pathology and clinical pathology. However, in event the pathologist is not qualified in clinical chemistry or clinical microbiology the services of a qualified clinical chemist and clinical microbiologist shall be readily available for supervision of work in these areas as required by the New York City Health Code.

(2) If the clinical laboratory service is under the supervision of a clinical laboratory director who meets the requirements of the New York City Health Code but is not a qualified pathologist certified in anatomical pathology, the licensee shall provide the services of a qualified pathologist certified in anatomical pathology as required by this code, (see Section 15.02(k).)

(d) Control. The licensee shall not transfer the ultimate responsibility for the operation of the Pathology and Clinical Laboratory Department, the protection of the patients or compliance with this code. However, the technical conduct of the department shall be the responsibility of the chief pathologist.

(e) Scope of service. The pathology and clinical laboratory service or department or a central laboratory, if such is established shall provide the following types of examination as a minimum:

(1) Microbiology and serology including primary cultural studies on tissues, body fluids and exudates (e.g. urine, blood, stool, spinal fluid, wound exudates) as well as appropriate staining procedures, antibiotic sensitivity tests and routine serologic tests.

(2) Basal metabolism determination, or other metabolic tests as required.

(3) Clinical chemistry, including the usual routine procedures and special tests as required to maintain high standards of medical practice.

(4) Hematology, including all routine and special tests required in the current practice of medicine.

(5) Tissue pathology and exfoliative cytology, including the ready availability of the pathologist for consultation regarding diagnosis when necessary.

(6) Autopsy service.

(7) It shall be the sole responsibility of the chief of the department to select a "reference laboratory" for complex procedures which cannot be performed in the laboratory of an individual hospital or for those procedures which are only occasionally requested or those beyond the competence of the technical staff. Such a "reference laboratory" shall conform to the requirements of the New York City Health Code and shall be located inside the geographical boundaries of New York City. This provision does not apply to specimens sent to the State and United States Public Health Laboratories.

(f) Laboratory technicians shall meet registration standards for medical technologists as prescribed in the New York City Health Code.

(g) Availability of personnel. A call system shall be in operation under which a technician shall be promptly available for the performance of emergency tests.

(h) Laboratory controls. Suitable controls shall be established as required by the provisions of the New York City Health Code.

(i) Patient identification. The laboratory request and the laboratory report forms shall contain sufficient information so that a given specimen shall at all times be identified positively with the patient from whom it was taken.

(j) Records. A laboratory report on each procedure or autopsy, indicating the individual who performed the test or examination, shall be filed in the patient's medical record, and at least one (1) copy thereof shall be retained in the laboratory. All laboratory records shall conform to the requirements of the New York City Health Code.

NOTE: The director of the clinical laboratory or other pathologist shall be present in the hospital at least seven (7) hours each day for at least five (5) days per week.

§15.14. Blood Bank

(a) A hospital shall maintain a blood bank or a blood storage facility which shall comply with the provisions of the New York City Health Code.

(b) Physician-in-charge. The licensee shall designate a director of the blood bank as required by the provisions of the New York City Health Code.

(c) Availability of blood.

(1) There shall be at all times in the hospital an adequate supply of blood, plasma and sterile parenteral fluids immediately available as well as facilities and personnel for its typing and administration.

(2) Emergency supply. The hospital shall make arrangements to secure on short notice all necessary supplies of whole blood, typed and cross-matched as required.

(3) Source of supply. The hospital shall establish a stable source of supply of human blood, whether through an integrated blood bank operation or by arrangement with an outside blood service.

§15.15. Podiatry Service or Department

(a) Podiatry staff. Podiatrists shall be eligible for membership in the surgical department and shall be subject to the regulations thereof.

(b) Medical supervision. A patient in need of podiatry care shall be admitted by and shall be under the care of a staff physician.

(c) Applicability of general requirements to podiatry patients. The requirements of this code regarding patients, particularly the requirements on admission examinations, standard general clinical procedures, pre-operative procedures, anesthesia and medical records, shall be applicable to podiatry patients as well.

ARTICLE XVI ADMINISTRATIVE REQUIREMENTS FOR ANCILLARY AND MAINTENANCE SERVICES

Section

16.01. Central Sterile Supply.
16.02. Pharmacy Service.
16.03. Medical Records Department.
16.04. Medical Library.
16.05. Educational Services.
16.06. Ambulatory Patient Services.
16.07. Medical Social Service.
16.08. Nursing Service.
16.09. Emergency Department.
16.10. Dietary Service.
16.11. Housekeeping Service.
16.12. Laundry and Linen Service.
16.13. Plant Maintenance and Engineering Service.

§16.01. Central Sterile Supply

(a) Each hospital shall provide, prepare, sterilize, store and dispense sufficient sterile supplies and medical and surgical equipment to all departments and services of the hospital to ensure that medical and surgical asepsis is maintained in carrying out all diagnostic, treatment and surgical procedures. The operation of this sterile supply service shall be carried on in an area designed, equipped and staffed specifically for this purpose.

(b) Supervision. The licensee shall place the responsibility for the supervision of sterilization under the Director of Nursing or under a supervisor who has had special training in this work and who shall be responsible to the Director of Nursing.

(c) Standards of performance. An in-service training program shall be conducted for all personnel assigned to this department. Written standards of performance shall be made available at all times by the hospital to all personnel responsible for sterilization of equipment and supplies. These standards shall contain but not be limited to:

(1) Stipulations as to minimum time and temperature for processing various types of bundles and packs.

(2) Instructions for cleaning, packing, storing and issuance of sterile supplies.
(3) Instructions which specify that every bundle or pack sterilized shall bear a clear imprint reading "Sterility Expires" together with a clearly marked date which would indicate the period during which the pack or bundle may be considered sterile.
(4) Instructions for loading and operating sterilizers.
(5) Procedures for maintaining and recording each sterilizing cycle used.

(d) Sterilizing records. The following records shall be maintained in conjunction with sterilizing services:
(1) Services performed by the specific unit.
(2) Current charts of recording thermometers or daily record of sterilizing cycles (date, time, temperature, pressure, contents) for each sterilizer load.
(3) Results of periodic cultures of items which are sterilized.

§ 16.02. **Pharmacy Service**

(a) A hospital shall maintain a pharmaceutical service and shall employ a full-time pharmacist who is currently licensed in the State of New York. Where applicable, the operation of the pharmacy shall comply with the requirements of the New York City Health Code.

(b) Function of the pharmacist. The pharmacist shall have immediate supervision over and be responsible for:
(1) The compounding of all medications which are prepared in the hospital.
(2) The dispensing of drugs to in-patient and ambulatory services.
(3) The filling and labeling of all drug containers issued to nursing units from which medication is to be administered to patients.
(4) The inspection of all pharmaceutical supplies on nursing units, in operating rooms and delivery rooms, and any other areas where pharmaceutical supplies may be stored or dispensed.
(5) The dispensing of all narcotic drugs, alcohol and barbiturates and the control of inventory of such items.
(6) The control of temperature environment and expiration dates of all biologicals and other dated drugs.

(c) Administrative supervision and control. The licensee shall be responsible for all procedures adopted by the pharmacy and for developing and maintaining a requisitioning and distribution system for all hospital units.

(d) Pharmacy committee. A Pharmacy Committee of the medical staff shall be established. The pharmacist shall act as the secretary of this committee.

(e) Quality of pharmaceuticals. The hospital shall use drugs, chemicals and pharmaceutical preparations of at least the minimum standards called for in the following publications: The United States Pharmacopeia, the National Formulary and the New and Non-official Drugs.

(f) Stop orders. All drug orders for narcotics, sedatives, hypnotics, anticoagulants and antibiotics shall be automatically discontinued after forty-eight (48) hours unless the order indicates an exact number of doses to be administered, or an exact period of time for the medication is specified or the attending physician reorders the medication. The controlling policy regarding stop orders on all other medications shall be determined by the Medical Board.

(g) Pharmacy library. The hospital shall maintain a pharmaceutical reference library, including but not limited to: United States Pharmacopoeia, National Formulary, New and Non-Official Drugs, United States Dispensary, and other reference works on Chemistry, Pharmacology and Bacteriology, as recommended by the Pharmacy Committee.

§ 16.03. **Medical Records Department**

(a) The hospital shall maintain a Medical Records Department.

(b) Responsibility. The licensee shall be responsible for the proper maintenance of all medical records. The licensee shall be responsible that the medical record on every patient admitted for care shall be completed, including the processing and indexing of pertinent data and the preparation of derivative reports.

(c) Supervision. The licensee shall appoint a full-time librarian to supervise the department. The librarian shall have the qualifications required by the American Association of Medical Record Librarians for medical record librarians or medical record technicians or shall have had training and experience acceptable to the Commissioner.

(d) Responsibilities of the Medical Record Librarian.
(1) The head of the department shall plan, organize and manage an efficient Medical Records Department;
(2) Promote the prompt completion of all medical records;
(3) Assure that the records are of uniform and good quality;

(4) Cooperate with other departments to coordinate records;
(5) File and cross-index records;
(6) Assist the Medical Record Committee of the Medical Board in reviewing and evaluating the medical records;
(7) Prepare monthly, annual and periodic medical statistical reports;
(8) Assist the medical staff to collect scientific data from the medical records for educational and investigative purposes.

(e) Content. The Medical Board, or the Medical Record Committee, shall specify the standard contents of each patient's medical record and shall approve the forms to be used. They shall establish means for follow-up to assure prompt completion and authentication of each record, in accordance with the by-laws and rules and regulations of the medical staff.

(f) Indexing. Either the International Classification of Diseases or the Standard Nomenclature of Diseases and Operations shall be used for the indexing of hospital records by diseases and operations. If the International Classification is used for indexing, the diagnostic terms used by physicians shall conform with those of the Standard Nomenclature of Diseases and publication published by the American Medical Association.

(g) Filing system. An efficient and effective unit system of filing of all medical records shall be maintained. All clinical information pertaining to a single patient shall be centralized in the patient's record.

(h) Length of time for records to be kept. All medical records shall be kept readily accessible for a period of at least six (6) years. In the event that a hospital discontinues operation for any reason whatsoever, the licensee immediately preceding the discontinuance of the operation of a hospital shall maintain, store and service, in New York City, all medical records for a period not less than that required herein. The licensee shall notify the Department, in writing, where the medical records will be stored and serviced.

(i) Confidential nature of records. Information contained in patients' medical records is privileged and confidential. Disclosure of such information to unauthorized persons without the consent of patients or their sponsors is prohibited.

(j) Use of medical records for staff and other research purposes shall be governed by policies to be adopted by the hospital upon recommendation of the Medical Board.

§ 16.04. Medical Library

The hospital shall maintain a medical reference library in accordance with needs to be established by the Medical Board, and as required by the Joint Commission on Accreditation of Hospitals. The licensee shall provide basic textbooks and current medical periodicals as determined by the Medical Board or a Library Committee of the Medical Board. These shall be catalogued according to standard cataloguing methods for ready reference by the medical staff. The licensee shall provide experienced and trained personnel to operate the library. Such personnel may be engaged in other capacities.

§ 16.05. Educational Services

A hospital which maintains professional educational training programs shall apply for approval of such programs from the appropriate professional organizations within a reasonable period of time. All such programs shall be as approved by the Commissioner and he shall be kept informed of all such programs and of the results of all surveys and evaluations of such programs by the appropriate professional orgahizations.

This provision shall not apply to in-service training programs.

§ 16.06. Ambulatory Patient Services

A hospital may elect to maintain a service for the examination and treatment of ambulatory private patients.

If the hospital operates an ambulatory patient service, the licensee shall:

(a) Employ such licensed para-medical, professional and non-professional personnel as are required for efficient operation of this service.

(b) Provide facilities to assure efficient operation of the service.

(c) Provide orientation and in-service education programs for all personnel.

(d) Maintain and correlate the medical records of this service with other hospital medical records.

(e) Make provision for the medical staff to conduct departmental and interdepartmental medical conferences in respect to the care given patients in this service.

(f) Make provision for close liaison between the various sections of the ambulatory patient service and other hospital services.

(g) Construct, equip, staff and administer this service in accordance with all other pertinent requirements of this code.

§ 16.07. Medical Social Service

(a) If a hospital maintains a formally organized Medical Social Service, it shall meet the following requirements:

(1) The service shall be directed by a qualified medical social service worker.

(2) Facilities shall be provided which are easily accessible to patients and to the medical staff, and which assure privacy for interviews.

(3) Records of cases handled by the service shall be kept. Such records shall be available only to the professional personnel concerned.

(b) If a hospital does not maintain a formally organized service, the licensee shall be responsible for providing case work service to patients and their families at the request of the staff physicians. This service shall be provided by qualified social workers employed part time by the hospital or through the purchase of service from a recognized social agency.

§ 16.08. Nursing Service

(a) General requirements. The nursing services shall, at all times, provide for every patient such skilled nursing care and supervision as will protect the patient's physical and emotional well being.

(1) Supervision. The nursing service of the hospital shall be supervised by a registered professional nurse designated as "Director of Nursing". The Director of Nursing shall be currently registered in the State of New York and qualified by virtue of experience, special training and administrative and executive ability, to organize and supervise the nursing service. The Director of Nursing shall be responsible to the administrator for developing and having accessible in writing clearly defined nursing service functions, objectives and procedures. The Director of Nursing shall have no other functions, i.e., supervisor of the operating room. The Director of Nursing shall have an office equipped with a desk and with files or cabinets sufficient for the preparation and storage of necessary records and reports.

(2) Assistants to the Director of Nursing for evening and night services and supervisory and staff personnel for each department and each nursing unit are to be assigned to assure the immediate availability of a registered professional nurse for bedside care for all patients at all times.

(3) Licensure. All nurses employed by the hospital to practice professional nursing and/or practical nursing shall be currently licensed by the New York State Department of Education.

(4) Continuous nursing care required. There shall be on duty, at all times, at least one (1) registered professional nurse per shift for each nursing unit. In addition, the hospital shall provide other personnel to provide all patients with continuous nursing service.

(5) Special duty nurses. All nurses who render special duty service in the hospital shall be under the supervision of the Nursing Supervisor of the department or service concerned. They shall be currently licensed to practice nursing in the State of New York.

(6) Non-professional workers. All non-professional workers performing nursing service functions shall be under the supervision of registered professional nurses.

(7) Departmental plan of organization. The hospital shall have available at all times for inspection a departmental plan which shall include but not be limited to the number and responsibilities and duties of each category of nursing personnel. Nursing personnel shall be selected for their experience, ability and interest in the positions to which they are appointed. Written manuals of procedure shall be provided for the guidance of the administration and department heads and technical guidance of nursing department personnel.

(8) Nursing education. A program of regular monthly meetings of the nursing staff scheduled in rotation to review and analyze nursing services, to determine how to improve the quality and efficiency of nursing care, shall be developed and a continuous program of in-service education for all nursing department personnel shall be maintained. Minutes of all such meetings shall be kept.

(b) The supplies and equipment for each nursing unit shall include but not be limited to:

(1) Sterile supplies and equipment for the administration of blood transfusions and intravenous and subcutaneous solutions.

(2) Dressing trays. Dressing trays or carts with sterile goods and surgical supplies sufficient for routine treatment and for emergency needs.

(3) Thermometers. There shall be at least one (1) thermometer in use for each patient.

(4) Wheelchairs and stretchers. Wheelchairs and wheeled stretchers shall be available on each nursing floor in sufficient numbers to meet all anticipated needs.

(5) Oxygen. Provision shall be made for the administration of oxygen, including immediately available supplies of oxygen, masks, tubes, tents, canopies and all required oxygen control and measuring equipment and devices. Oxygen shall be administered in accordance with the provisions of this code.

(6) Portable solution stands or attachments to the bed for the proper subcutaneous and intravenous administration of solutions.

(c) Cleaning of materials and equipment.

(1) All supplies and equipment used in patient care shall be properly cleaned and sterilized when required and between use by different patients.

(2) Methods for cleaning, handling and storing all supplies and equipment shall be such as to prevent the transmission of infection through use.

(3) After discharge of a patient from the hospital, the bed, mattress cover, bedside furniture and equipment shall be properly and thoroughly washed and/or sanitized.

(d) Application of heat. Hot water bags shall be covered before use. Electric heating pads shall not be used in combination with wet dressings. Such pads shall be maintained in safe working order and shall be of a design approved by the Underwriters' Laboratories.

(e) Restraints for other than safety reasons.

(1) Restraints shall not be applied unless required to prevent injury to the patient or to others, and shall be used only when alternative measures have failed to accomplish these purposes.

(2) Restraints shall be applied only on the written order of a physician which shall indicate the type of restraint, the reason therefor and the period during which the restraint is to be applied.

(3) Restraints shall be of a type which can be removed promptly in event of fire or other emergency.

(4) Restraints shall not be used or applied in such a manner as to cause injury to the patient.

(5) The maximum period, in the daytime, during which a patient may be continuously kept in restraint shall be two (2) hours, after which the patient shall be released for a reasonable period of time. Such a patient shall be visited once every half-hour or more often if necessary during that period. At night, the patient shall be removed from restraint every two (2) hours except when asleep.

(6) In case of an emergency, a restraint may be applied temporarily pending the arrival of the patient's physician.

(f) Specialized nursing services.

(1) Operating room nursing service. Nursing personnel employed in the operating suite shall be subject to the following rules and regulations:

(a) Operating room supervisor. A registered nurse with post-graduate education or experience in operating room technique shall be designated to supervise the operating room service. The operating room supervisor shall be responsible for the following:

(1) In cooperation with surgeons and anesthetists, so order and supervise the personnel, material resources and environment as to safeguard the patient in all surgical procedures.

(2) Determine the training needs of her personnel and conduct training as needed.

(3) Maintain the register of operations.

(4) Have access to appropriate medical staff and administrative officers when necessary in the interest of establishing policies.

(5) Report to the Director of Nursing on the work and needs of the operating room service.

(6) Prevent nursing personnel assigned to the operating suite from being assigned to other duties in wards or services which may create danger of infection.

(b) Whenever a patient is in an operating room, there shall be present and on duty in that operating room at least one (1) registered professional nurse who shall have had experience in operating room technique.

(c) The number of nursing personnel to be assigned to the surgical suite shall be commensurate with the size and degree of activity and shall be shown in the table of organization of such personnel as is provided to the Commissioner.

(2) Maternity and Newborn Service. A hospital with a maternity service shall assign nursing and other personnel in accordance with the provisions of the New York City Health Code.

(3) Pediatric service. A hospital with a pediatric service shall adopt the following rules in respect to nursing supervision and nursing staff of pediatric services:

(a) Continuous coverage. Registered nursing personnel shall be assigned to the pediatric nursing unit so as to maintain constant supervision of children twenty-four (24) hours each day.

(b) A registered nurse with post-graduate education and experience in pediatric nursing shall be designated to supervise the pediatric service.

(4) Psychiatric Nursing Services. A hospital with psychiatric in-patient services shall conform to the requirements of the New York State Department of Mental Hygiene.

§ 16.09. **Emergency Department**

Each hospital shall maintain an Emergency Department as set forth in this code.

(a) Responsibility. The licensee shall appoint a physician who shall serve as physician-in-charge of the Emergency Department. He shall be responsible for the prompt and efficient treatment of emergency patients and the coordination of physician coverage according to a plan to be established by the Medical Board and approved by the licensee.

(b) Coverage. A schedule shall be devised to provide prompt medical attention for all emergency patients as the need may dictate. This plan shall provide for reception, evaluation and treatment of emergency patients and for specialist consultation. A roster of "on-service" coverage by members of the medical staff shall be established.

(c) Nursing personnel.

(1) At least one (1) licensed nurse shall be assigned to Emergency Department duty at all times. This assignment need not be exclusive of other duties, but must have priority over all other duties whenever a patient is brought to the Emergency Department. Alternates shall be assigned in order that coverage be continuous. Regular and alternate personnel, if assigned other duties, shall be stationed within easy reach of the Emergency Department.

(2) Training. All nursing personnel assigned to the Emergency Department shall receive such orientation and training in the reception and treatment of emergency patients as deemed advisable by the physician-in-charge and the hospital administrator. Such training shall include at least the equivalent of a Red Cross First Aid Course. An outline or check list covering such instruction shall be maintained in a current form.

(d) Equipment and supplies. The emergency suite shall be provided with the necessary equipment including but not limited to:

(1) Examining table.
(2) Wheeled stretcher.
(3) Wheel chair.
(4) Resuscitation devices with oxygen supply.
(5) Inhalator attachments or accessories, including masks.
(6) Mechanical suction devices, including stomach pumps.
(7) Spotlight.
(8) Irrigation stands.
(9) Pressure sterilizers unless this procedure is performed elsewhere.
(10) A refrigerator.

In addition, complete trays for catheterizations, cutdowns, lavage, intulations and tracheotomys, blood pressure sets, ophthalmoscopes, percussion hammers, surgical instruments, needles, syringes, drains, assorted splints and miscellaneous equipment, as specified by the Medical Board and the Physician-in-charge.

(e) Medications and solutions. The following items or classes of items, subject to specification in each case to be determined by the Physician-in-charge and the Medical Board shall be immediately available:

Local anesthetic and analgesic agents;
Antibiotics;
Antidotes to poisons;
Antiseptics;
Antitoxins;
Blood;
Blood plasma, Fibrinogen;
Parenteral Fluids, including Blood Plasma Expanders;
Sedatives;
Stimulants, Cardiac and Respiratory;
Others as determined by the medical staff.

(f) Written standards. The medical staff shall formulate complete lists of standard equipment and supplies for emergencies, including those required in this section. Copies thereof shall be posted in the Emergency Department and shall indicate the location of each item or class of items.

(g) Written procedures. An Emergency Department procedure manual shall be compiled, composed of procedures (for personnel or house staff physicians) regarding initial handling of various types of injuries, poisonings, staff physicians on call, etc. This book is not to replace training requirements.

(h) Coordination with other departments. Provisions for prompt care of emergency patients shall include, as a minimum, a call schedule or procedure applying to the following services and departments:

General Surgery and Surgical Specialties; Anesthesia, Departments of Medicine, OB-GYN and Pediatrics; Central Supply; Delivery Room;
Laboratories; Operating Rooms; Pharmacy; Radiology Department; Blood Bank.

(i) Records. A record shall be made and maintained of each patient examined and treated in the Emergency Room, including date, name, address, age, place of injury, diagnosis, treatment, disposition, and name of physician.

(j) Emergency telephone calls.

(1) Call schedule. Assignment schedules, names, addresses and telephone numbers of all physicians and other personnel including alternates on emergency call duty, shall be maintained at the hospital switchboard and in the emergency department.

(2) Advice in emergencies. Switchboard operators shall have readily available written instructions for the handling of outside calls requesting aid or advice in emergencies.

(3) Poison control. The location and telephone number of the New York City Health Department Poison Control Center shall be maintained at the telephone switchboard and in the Emergency Department. A list of poison antidotes shall be maintained in the Emergency Department and in all nursing stations. A list of persons on call for poison emergencies shall be posted in the Emergency Department and at the telephone switchboard.

§ 16.10. Dietary Service

(a) General. All food shall be served to patients in a palatable and attractive state and at the proper temperature.

(b) Administration.

(1) Responsibility. The responsibilities of the Dietary Service shall include the administration of the general food service and the scientific management of therapeutic diets and may include the instruction of patients and of physicians, nurses and dietitians-in-training.

(2) Supervision. The dietary service shall be under the regular supervision of a qualified dietition or nutritionist.

(3) The department head shall prepare written instructions pertaining to dietary department practices and procedures, with which each dietary employee shall be familiar. A continuous, organized in-service training program shall be maintained for personnel.

(c) Management.

(1) Patient's food and nutrient needs shall be met in accordance with the current Recommended Dietary Allowance of the Food and Nutrition Board of the National Research Council adjusted for age, sex and activity.

(2) Menus.

(a) All menus shall be planned and written at least one (1) week in advance.

(b) Menus shall be different for the same days of consecutive weeks and adjusted for seasonal changes.

(c) Menus shall be reasonably adapted to the food habits of the patients.

(d) Menus shall be kept on file for thirty (30) days.

(d) Physicians' orders for regular and special diets.

(1) Therapeutic diets, ordered by physicians, shall be served as prescribed.

(2) Food orders for each patient shall be written and signed by the attending physician.

(e) Personnel and facilities for personnel.

(1) Adequacy. There shall be adequate dietary personnel to provide for the safe preparation and serving of food and beverages to patients and employees of the hospital. A table of organization for the department, showing job assignments and work schedules, shall be available in the hospital for inspection at all times.

(2) Health.

(a) Examination of food handlers. In addition to the general personnel provisions of this code, every person employed in food service shall furnish information, permit physicial examination, and submit laboratory specimens as the Department may require, or as may be required by the Department of Health, for the purpose of determining freedom from infectious disease.

(b) All food service personnel shall have clean hands and fingernails.

(c) They shall wear clean, washable outer garments.

(d) They shall be free of communicable diseases and open infected wounds.

(e) They shall observe all food handling requirements of the Department of Health.

(f) Food and drink.

(1) All food and drink shall be held, prepared and served in such a manner that it will not transmit illness to the consumer and shall comply with the requirements of the Department of Health.

(2) Only pasteurized milk and milk products shall be used.

(3) All milk and fluid milk products shall be served from the individual original containers in which they are received from the distributor, or from a bulk container equipped with a dispensing device approved by the Department of Health.

(4) All meat products used in the hospital shall have been inspected and passed by a City, County, State or Federal meat inspection agency as required by the Department of Health.

(g) Sanitation.

(1) The washing, sanitizing and storing of dishes, utensils, trays and food carts shall comply with the requirements of the Department of Health.

(h) Food service to communicable disease patients in isolation shall be in single-service dishes, cups and utensils.

§ 16.11. Housekeeping Service

(a) General. The hospital, including fixtures, walls, floors, ceilings and furnishings, shall be kept clean, free of vermin and rodents and of all accumulations of dirt and rubbish and free from foul, stale or musty odors. Floors, walls and ceilings shall be kept in good condition and walls and ceilings shall be washed and/or painted as frequently as necessary to assure compliance with this code and also to assure an attractive appearance.

(b) Responsibility. The Licensee or the Administrator shall be responsible for the housekeeping service and shall assign responsibility for its direct supervision to a qualified housekeeper.

(c) Housekeeper qualifications.

(1) Experience in operating a hospital or hotel housekeeping service.

(2) A knowledge of the technical aspects of cleaning, supplies, equipment and materials.

(3) An ability to select, train, make assignments, and supervise personnel.

(4) A faculty for working with others and other departments of the institution.

(5) An understanding of budgeting and record keeping.

(d) Organization. A written table of organization and a cleaning schedule showing the duties of each employee and their assignments shall be available in the hospital at all times for inspection. Personnel employed in the housekeeping service shall include housemaids, porters, cleaners, laundry and linen room workers, except when laundry and linen services are under an independent supervisor and all other employees engaged in housekeeping functions. There shall be sufficient personnel employed to keep the hospital clean, sanitary and orderly at all times and to comply with the requirements of this code.

(e) Instruction of personnel. All personnel engaged in housekeeping activities in the hospital shall be given an orientation to and periodic follow-up training in housekeeping methods and techniques and in the handling of linen.

(f) Inspection.

(1) A regular schedule shall be established for the daily inspection of the hospital premises to assure cleanliness and sanitary practice.

(2) All areas of the hospital in which foods are stored, prepared, served or eaten shall be inspected frequently for infestation, by insects or rodents. Immediate measures shall be taken to exterminate any such infestation.

(g) Dust control. Dusting, sweeping and vacuum cleaning shall be performed in such a manner as not to spread dust particles in the hospital atmosphere.

§ 16.12. Laundry and Linen Service

(a) A hospital maintaining a laundry on its premises shall conform to the provisions of the New York City Health Code.

(b) Responsibility. The responsibility for supervision and maintenance of laundry and linen services shall be vested in one (1) individual, who shall have adequate delegated assistance. This function may be supervised by the person in charge of housekeeping services or by an independent supervisor.

(c) Laundry manager's qualifications.

(1) Experience in the operation of a hospital or a commercial laundry.
(2) An ability to select, train and supervise personnel and make work assignments.
(3) A general knowledge of all laundry equipment and the safety of their operation.

(d) Supply of linen. The hospital shall maintain at all times a supply of linens in excess of two and one-half (2½) times its average daily requirements, and shall have in the hospital, ready for use, a sufficient portion of this total supply of linens.

(e) Storage. There shall be separate areas and equipment for the storage and handling of clean and soiled linens.

(f) The physician-in-charge of the Pathology Service or the Chairman of the Infection Committee shall establish procedures for the autoclaving of linens which may be presumed to carry infectious agents, or for equivalent sterilization of such linens.

(g) Soiled linen. All soiled linen and clothing leaving the using area must be bagged in a clean laundry bag. Hand trucks used for transporting soiled linen shall not be used for clean linen. Laundry employees handling soiled linen shall wear gowns, gloves and face masks for protection.

(h) Clean linen. Clean linen and clothing shall be stored in a separate area, away from the soiled and finishing section of the laundry. Clean linen shall be covered during transportation from the laundry to the using area.

(i) Each of the following classes of laundry shall be transported, washed, and stored separately:

(1) Diapers.
(2) Linens from the newborn nursery.
(3) Radioactive contaminated linen.
(4) Linen from Isolation Rooms, infectious patients, and from the Pathology Department.
(5) All other linen and clothing.

(j) Blankets shall be treated to reduce the spread of infectious agents through dust.

(k) If a hospital contracts with another organization for the laundering of linens, the hospital shall be responsible that the requirements of this code and of the New York City Department of Health are observed by the selected organization.

§ 16.13. Plant Maintenance and Engineering Service

(a) Engineering service required.

(1) A hospital shall have an engineering service adequate to maintain its physical plant and equipment in good operating condition.
(2) The hospital as a whole and various parts, including all mechanical equipment, grounds, fixtures, walls, floors, ceilings and furnishings, shall be maintained in good repair.

(b) Personnel.

(1) Assignments. There shall be a definite assignment of maintenance functions to qualified in-plant engineering and maintenance personnel.
(2) Preventive maintenance training. All personnel engaged in maintenance activities shall be given an orientation to and follow-up training in preventive maintenance techniques. This training should include an understanding of the principles of cross-contamination.
(3) Instructions. Instructions for operating and maintaining equipment should be available to maintenance personnel. Vital functions and directions should be posted for permanent reference and emergency use.

(c) Inspection and repairs; preventive maintenance. Provision shall be made for regular and periodic inspection of all parts of the hospital plant and equipment by qualified personnel. There shall be a regular, routine program for servicing, cleaning, testing, repairing and replacing of all equipment.

(d) Records. Records of request for maintenance service, showing the date of request for service, the location and identification of equipment on which service was requested, and the date the service was performed shall be kept for at least one (1) year.

(e) Such plant maintenance and engineering services as are not provided by full-time employees of the hospital shall be contracted for through outside service organizations and the hospital shall provide adequate evidence of such contracts, including schedules of service and records of services rendered.

This resolution shall take effect immediately.

This resolution was adopted by the Board of Hospitals at its meeting held on June 17, 1964.

Dr. Ray E. Trussell, Chairman.
Dr. David A. Connors.
Mr. David M. Heyman.
Mr. John J. Lynch.
Dr. Peter Marshall Murray.
Dr. Willard C. Rappleye.
Dr. Howard A. Rusk.
Mr. Samuel A. Turvey.
Mr. Harry Van Arsdale.

Attest: ESTELLE RODMAN, Secretary to the Board of Hospitals.

Office-Supreme Court, U.S.
FILED
JUL 18 1966
JOHN F. DAVIS, CLERK

(38,440)

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1966

No. 277

DR. FRANK M. FERRANTE,

Appellant,

against

THE CITY OF NEW YORK, ROBERT F. WAGNER, as Mayor of the City of New York, and DR. RAY E. TRUSSELL, as Chairman and Commissioner of the Board of Hospitals of the City of New York,

Appellees.

MOTION TO DISMISS

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